COLORADO
Department of Health Care Policy & Financing

2021
Quality Strategy
Evaluation & Effectiveness Review

Health First COLORADO™
Colorado's Medicaid Program

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TABLE OF ACRONYMS

Name	Acronym
Accountable Care Collaborative	ACC
All-Payer Claims Database	APCD
Centers for Medicare and Medicaid Services	CMS
Child Health Plan *Plus*	CHP+
Colorado Department of Public Health and Environment	CDPHE
Consumer Assessment of Healthcare Providers and Systems	CAHPS
Denver Health Medical Plan	DHMP
Early Periodic Screening, Diagnostic and Treatment	EPSDT
Encounter Data Validation	EDV
External Quality Review/Organization	EQR/O
Fee-for-Service	FFS
Health Information Exchange	HIE
Health Services Advisory Group	HSAG
Healthcare Effectiveness Data and Information Set	HEDIS®
Health Care Policy & Financing Department/HCPF	the
Limited Managed Care Capitation Initiative	Medicaid MCO
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Rocky Mountain Health Plan Prime	RMHP Prime
Substance Use Disorder	SUD
Turn Around Time	TAT
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Introduction

In accordance with 42 CFR 438.340(c)(2)(i), 438.340(c)(2)(ii), and 457.1240(e) Health First Colorado (Colorado's Medicaid program) as administered by the Department of Health Care Policy & Financing (the Department, or HCPF), is pleased to present our written evaluation and effectiveness review for assessing and improving the quality of managed care services. Health First Colorado, which is funded jointly by a federal-state partnership, administers coverage to approximately 1.4 million Coloradans and serves as a national model for implementing an innovative Fee-for-Service (FFS) and managed health care system for managing costs, utilization, and quality.

§432.202(d) The Department assesses the effectiveness of the quality strategy, revises and modifies the strategy when significant change occurs pursuant to any new regulatory reference at §438.340(b)(11). Reviews include an evaluation of the effectiveness of the Quality Strategy using data from multiple data sources. At a minimum, the Department Strategy is updated every three years or if there is a significant change due to new and amended federal/state regulations, changes to Department programs, policies, and procedures, or based on the Department's data analytics highlighting the need for change.
The Department's Quality Strategy is published to our website for public comment and takes public recommendations into consideration for updating the quality strategy.

https://www.colorado.gov/pacific/hcpf/quality-and-health-improvement-reports

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Evaluation & Effectiveness

Goals & Objectives of the States Managed Care Program

The Department, in alignment with the Governor's health care priorities, continues to focus on reducing health care costs while ensuring culturally responsive and equitable access to care by expanding access to comprehensive primary and behavioral health (BH) services for the Medicaid and Child Health Plan *Plus* (CHP+) population, based on the following defined goals and associated performance measures:

- **Health Care Affordability for Coloradoans: Reduce the cost of care in Colorado**
  The Department created a Health Care Affordability Roadmap that identities cost drivers and cost control policies to address them. The Roadmap is intended to inform the State's and Medicaid's affordability strategy and align the two. This goal is formulated to achieve improvement in the areas of price constraint, alternative payment models, data infrastructure, innovation, and population health, as reflected by the following performance measures

Performance Measures	FY 19 YE	FY 20 Q3	1-Year Goal
# State thought leaders, industry influencers and stakeholders who are aware of, engaged to develop, or supporting the execution of the 3-5+ Year Health Care Affordability Road Map	2,200	4,310	3,500
% Complete: Prescription Cost Drivers Report	N/A	100%	100%
% Complete: Payer Prescription Tool Implementation	N/A	21%	100%
% Complete: CMS Approval for HTP Waiver	N/A	82%	100%
# HTP measures implemented	N/A	9	10

The Department met or exceeded all but one of the measures by the end of FY 2019-20. Implementation of the Payer Prescription Tool is on track for completion in FY 20-21

- **Medicaid Cost Control: Ensure the right services for the right people at the right price**
  Since the passage of Colorado's Senate Bill 18-266, Controlling Medicaid /costs, the Department has been focusing resources to meet the intent of the legislation and the affordability goals of Governor Polis. In addition to many cost control initiatives to better manage Medicaid expenditures, such as curbing fraud and evolving Accountable Care Collaborative (ACC) strategies, there are more than 15 workstreams inside the Department focused on Medicaid claim trend management. Most of the appropriations received by the Department are for the purpose of funding the State's Medicaid program. As such, it is

critical that the Department demonstrate sound stewardship of the financial resources that have been allocated to its programs

Performance Measures	FY 19 YE	FY 20 Q3	1-year Goal
$ Medicaid per-capita total cost of care (PMPY)	$6,378	$589	($570 ($6,839)
% Complete: Managing rising trends and high-risk, high-cost Medicaid members	N/A	70%	100%

[1] Annual goal is per member per year (PMPY). Quarterly data is per member per month for February 2020. The PMPY actual for FY20 will be calculated after the end of the FY.
[2]1-year goal adjusted in October 2019 based on changes in the November budget forecast for FY 2019-20
[3]$589 pmpm through February vs target of $570 pmpm (2.7% over, before application of rebates). Monthly Medicaid per capita fluctuates based on the number of weeks in a month, sudden changes in caseload (due to retroactive payments), what part of the year a month falls in, the timing of lump-sum payments, and other reasons based on provider billing fluctuations. Therefore, fluctuations in monthly cost per capita are normal in most cases.

The Department's Medicaid per capita expenditure was overstated at the end of the third quarter (shown above) because expenditure and utilization of services decreased due to the unprecedented Corona Virus 2019 (COVID-19) pandemic. Given the more recent forecast of reduced utilization due to the pandemic, per capita cost is likely to be on track with the target by the end of FY 2019-20.

The Department met its goal to complete implementation of a plan to manage rising trends and high-risk, high-cost Medicaid members.

- **Member Health: Improve Member Health**
  The Department seeks to improve the health and well-being of Coloradans served by the Medicaid program. Appropriate health care must be complemented by addressing chronic disease, mental health and substance abuse. The impact of the opioid crisis has devastated many American families and Colorado is no exception. The Department is implementing strategies to battle overprescribing behaviors and reduce patient addiction in the Medicaid and CHIP populations.

Performance Measures	**FY 19 YE**	**FY 20 Q3**	**1-Year Goal**
Decrease # of opioid pills dispensed among members who use Rx benefit[1]	8.26	7.60	7.46
% Complete: Baseline Risk Score for every member	N/A	80%	100%

[1]Data lagging—updated through December 2019.

The Department exceeded the target for both measures above by the end of FY 2019-20

- **Customer Service: Improve service to members, care providers, and partners**
  Our focus for this goal is on improving service to our members and providers to reach levels that parallel that of the private or commercial sector. We want to be diligent and thoughtful in finding ways to do more with less across all our operations in order to match the service levels associated with commercial payers

Performance Measures	FY 19 YE	FY 20 Q3	1-Year Goal
Provider call average speed of answers (ASA) in seconds[1]	52	180	61

[1]Quarterly data is from February 2020.

§438.204(b)(1) **Quality and Appropriateness of Care**

Key Indicators:

Utilization Review:
§438.210(e) Coverage and Authorization of Services

The Department's Utilization Management (UM) program for select FFS for State Plan Benefits, also known as the Colorado Prior Authorization (PAR) Program, is administered by a 3rd party vendor. The Department's current UM Contract with a Quality Improvement Organization (QIO), eQHealth Solutions, Inc, is scheduled to terminate in Spring 2021, and the Department has selected a new Vendor to administer the ColoradoPAR program, Keystone Peer Review Organization (KEPRO) with the new contract being executed in January 2021. The Department went through an extensive Invitation to Negotiate to evaluate potential UM Vendors, developing a scope of work and final drafted contract, and selecting a new UM Vendor with a focus on one that would contribute meaningfully to the effective and consistent administration of the Department's PAR program, and meeting established Department goals and priorities.

A considerable part of administering the ColoradoPAR program is ongoing evaluation of the success, effectiveness and consistent administration of the UM Program. As there are so many different components to the ColoradoPAR program, selecting only one area or metric to determine success and effectiveness is not sufficient. Nor can the Department look only to improvement in metrics to determine effectiveness but rather must also monitor select metrics for consistency. For this reason, the Department looks at many areas to determine the effectiveness of the program including review turnaround times, denial rates (full, partial, medical necessity and technical), cost savings, customer services metrics, benefit specific and quality metrics and there are multiple areas that the Department has tied certain performance standards to performance based payments. To determine the success and effectiveness of the PAR program, the Department looks for improvement in certain performance standards and metrics and/or the consistency of performance standards and metrics:

- The Department monitors the Denial rate to ensure that the rate of denials is fairly consistent, understanding there will be some minor changes but that if there is a significant change in the

denial rate there is a clear, understandable cause identified (such as a change in policy and/or requirements). At the beginning of 2020, the overall denial rate was 11.32% and at the end of 2020 the denial rate showed slight improvement at 12.33%.

- The Department began monitoring the Inter-rater Reliability (IRR) scores for the UM Vendor in 2020 and will continue to monitor these with the new UM Vendor as these scores ensure that the reviewers are applying policy, rules and regulations and clinical criteria appropriately and consistently. For 2020, the average IRR score for Quarter 1 was 97.5% and increased consistently over time with CY 2020 ending with an average IRR of 100%.

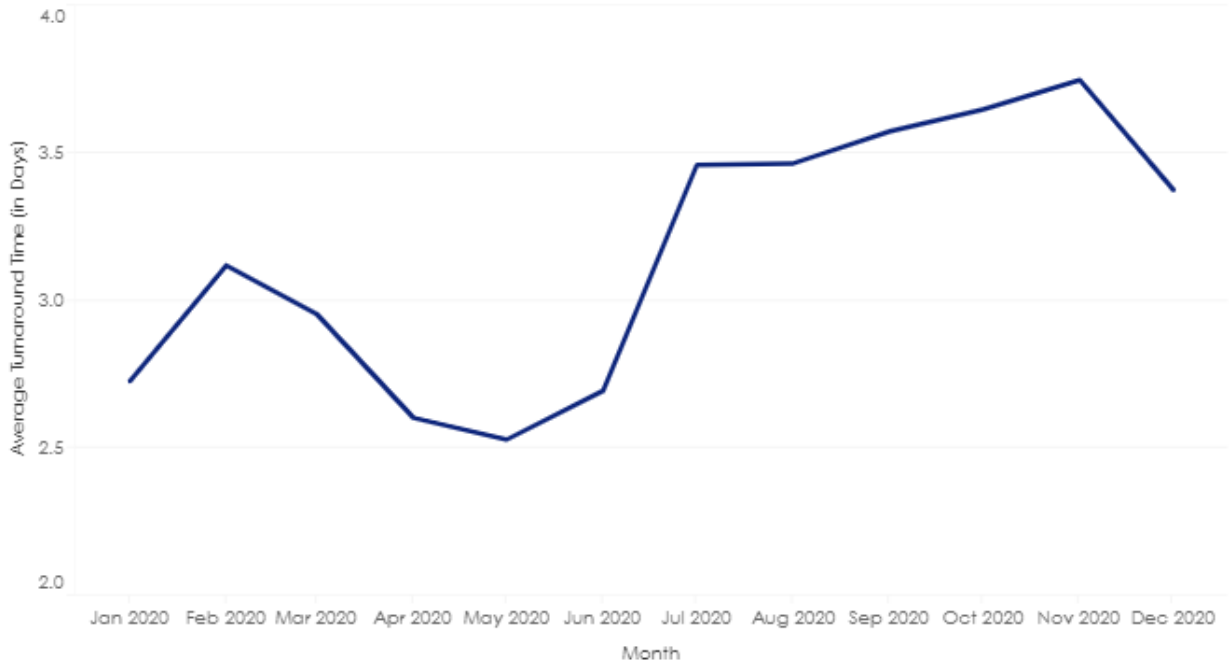
- Additionally, on a weekly basis, the Department monitors the review Turn Around Time (TAT) and TAT for PAR determination completion ranged from 2.55 Business Days to 3.83 Business Days for 2019 (Figure 1 below). For CY 2020, the TAT has remained consistent ranging between 2.53 to 3.75 Business Days during the 12-month period (second Figure 2 below). The Department currently requires that the average TAT is equal to or less than 4 Business Days.

Figure 1

February 2019-January 2020 Review Turn Around Time Average

Figure 2

January 2020-December 2020 Review Turn Around Time Average



Dental ASO

Rising cost in healthcare have created a need to accurately assess quality and efficiency in oral care. Establishing measures to identify and monitor innovative strategies to reduce incident of oral disease while driving improvement on performance-based outcomes is an important Department priority. To effectively measure oral care the Department utilizes data from various administrative sources (encounters and claims), patient records, and surveys which assist the Department in making policy decisions, based on identified key performance measures. For FY 2018-2020 the Department focused on the following Dental performance measures:

CHP+ Measures – Fiscal Years 2018, 2019, 2020

CMS CARTS Report (Overall Utilization – Percentage of Members Receiving Any Dental Service)

FY 20	41.81%⬇
FY 19	42.36%⬇
FY 18	43.08%

⬇ Indicates a decrease

Measure performance reflects a decrease from FY 18 to FY 19 which is attributed to Contractor eligibility file processing issues. Due to these issues, the Department suspects the total number of

eligible members is lower because of duplication within the Contractor system. In July 2019, the Department initiated a new contract with DentaQuest USA Insurance Company, LLC. The FY 20 percentage reflects a decrease for members receiving services due to the unprecedented COVID-19 pandemic.

The Department's current CHP+ Contractor has active member outreach efforts in place to further drive performance improvement on this goal, including the development and distribution of electronic resources on oral health for children and families, virtual presentations (in urban, rural and frontier communities) to members and community partners on CHP+ dental benefits, the importance of oral health and how to access care during the pandemic, and coordination with dental providers across the state to ensure members receive timely and accurate information about their dental benefits.

CHP+ Performance Improvement Project (PIP)

FY 20	No results
FY 19	No results
FY 18	N/A

In October of 2018, it was determined that the dental CHP+ benefit qualified as a Prepaid Ambulatory Health Plan (PAHP) and certain quality measurements and activities would apply. With that said, there was no activity in FY 18 due to lack of qualification as a PAHP. In FY 19, the PIP activities began late in the cycle due to determination of PAHP status in October 2018. The previous Contractor, Delta Dental of Colorado, completed 2 modules but did not finish the project because they exited the contract in June 2019. For FY 20, the new Contractor, DentaQuest, resumed the PIP project and completed 2 modules. Modules 3 & 4 were in progress when COVID-19 hit. In April of 2020, the Department made the decision to stop work on the PIP projects considering COVID-19 issues with access to all medical and dental services, and to allow the health plans to focus on new challenges due to COVID-19. The PIP project has restarted for FY 21.

Medicaid Measures (Overall Utilization – Percentage of Members with Diabetes Diagnosis Receiving Dental Services)

FY 18	Dental Utilization for Children	52.32% to 53.49% = 1.17% ⬆
FY 19	Diabetes Performance Incentive Project	36.09% to 31.18% = -4.28% ⬆
FY 20	Physician and Dental Visit Performance Incentive Project	23.6% to 24% = 0.4% ⬇

⬆ Indicates an increase ⬇ Indicates a decrease

In FY 18, DentaQuest was tasked with increasing the number of children who visited a dentist during the year by at least 2 percentage points to meet Tier 1 goals. The Department did see an increase of 1.17%, but it was not enough to meet the goal.

In FY 19, DentaQuest was tasked with increasing the number of members with diabetes who have a preventive dental visit during the year. In FY 19, the number of members with a diabetes diagnosis who visited the dentist decreased 4.28%. The Department does not have any data to explain why the overall decrease occurred; however, the number of members with a diabetes diagnosis receiving preventive services only decreased slightly by 1.78%.

For FY 20 which was the first year of the new contract cycle, DentaQuest was tasked with increasing the percentage of members who have both a dental and medical (PCP) visit within the same year. The performance incentive was tiered with Tier 1 a 2% increase from baseline, Tier 2 as a 5% increase and Tier 3 with an 8% increase. DentaQuest made some progress with a 0.4% increase from baseline but did not meet any of the tiered levels.

The dental strategy for FY 21 is to allow DentaQuest to continue work toward the dental and medical (PCP) visit performance incentive to promote continuity and see more progress toward the goal. The Department believes that one year is not enough time to build and promote a program targeted toward the chosen measure in order to see positive results come through especially during an unprecedented pandemic.

§438.204(b)(2) Member Demographics

As thousands of Coloradoans continue to lose their employer-sponsored health coverage during the COVID-19 pandemic, the Department anticipates additional Coloradoans will continue to enroll in the Health First Colorado program and CHP+ programs.

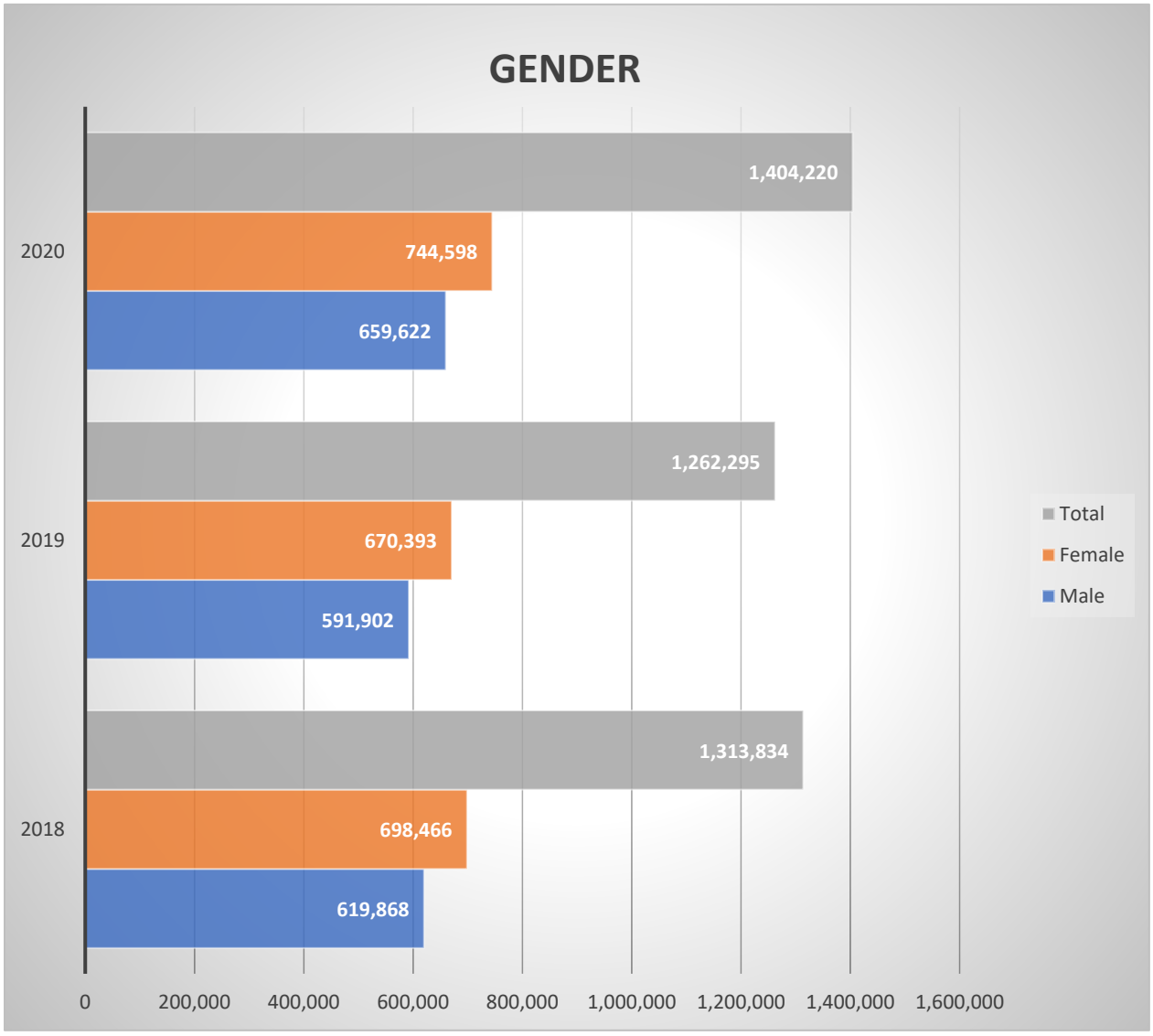
Drivers of this increase are two-fold:

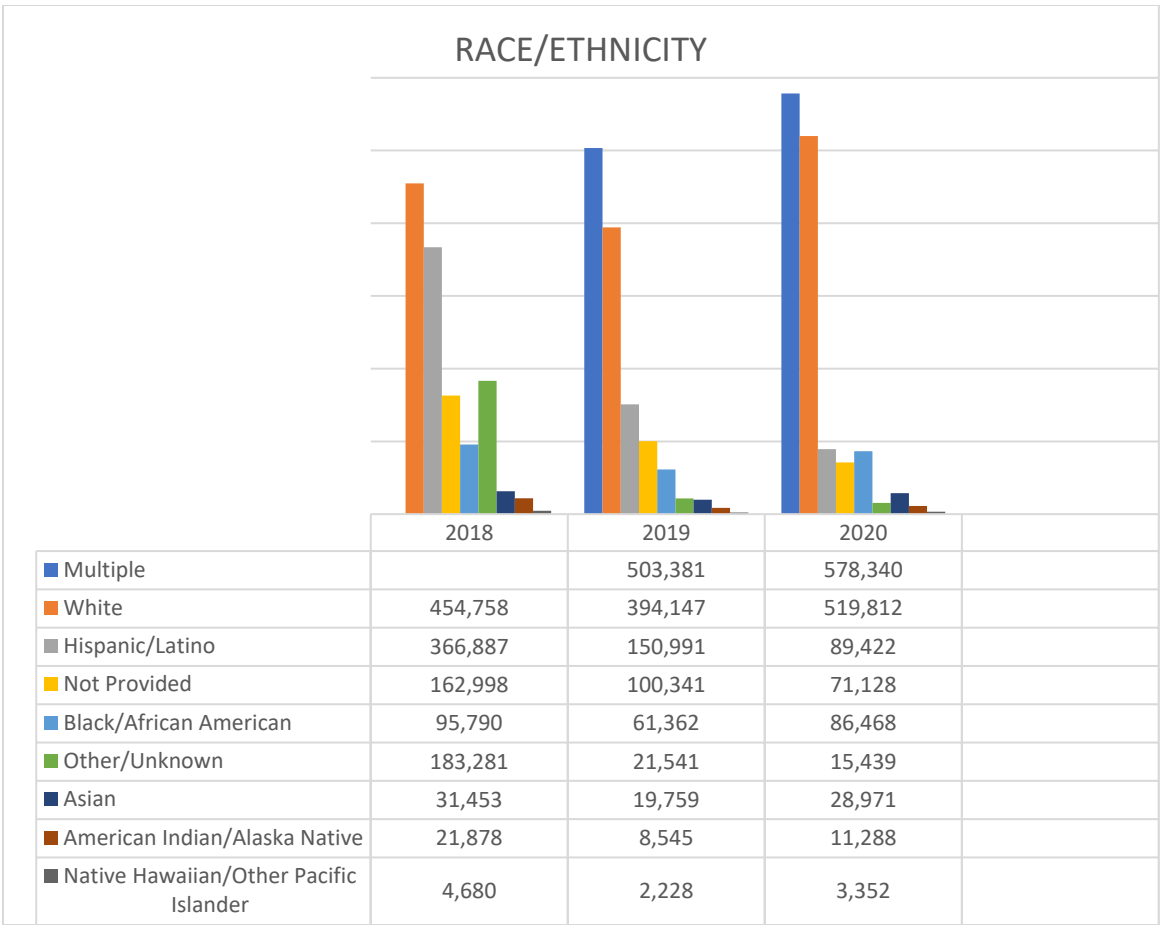
1) The unemployment rate which is now 11.3%, up from 2.5% in February 2020 is the highest since the state began tracking unemployment in 1976. As Coloradoans lose their jobs due to the economic downturn caused by COVID-19, they often lose their employer-sponsored health coverage, as well.

2) The second driver of the projected enrollment increase is the impact of the federal public health emergency, which requires the Department to refrain from disenrolling members from Medicaid during the emergency period.

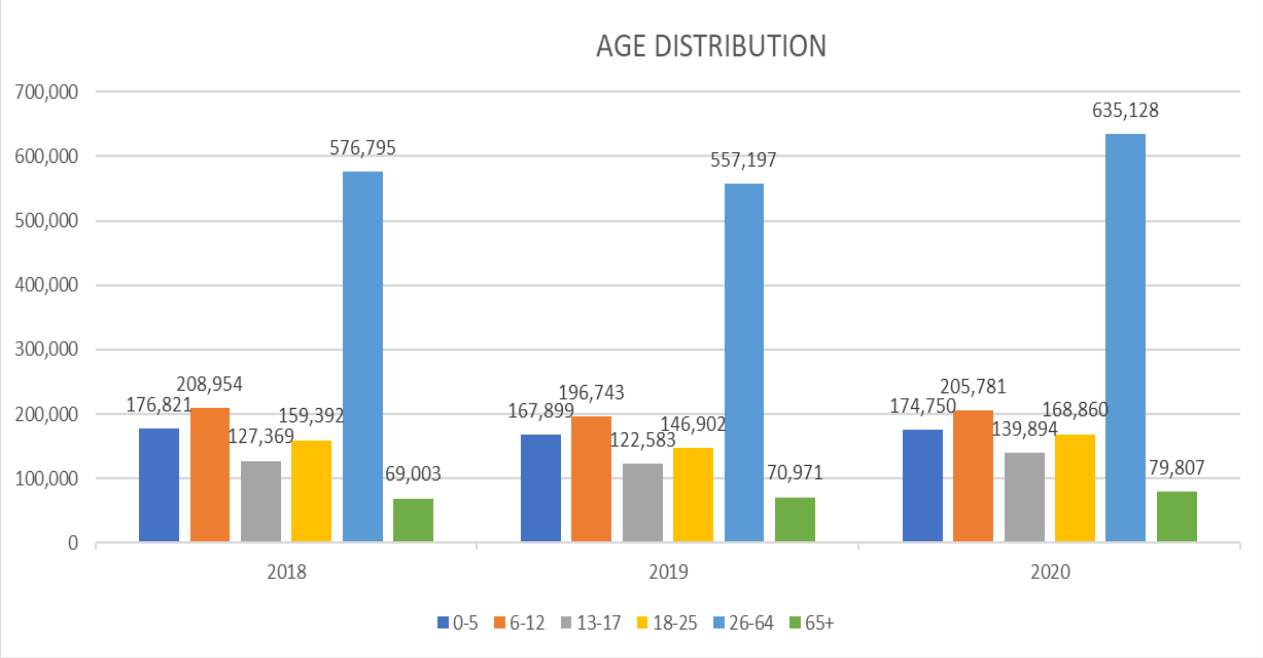
Change within member demographics for the time period of 2018-2020 are reflected below:

First Health Colorado Medicaid Membership

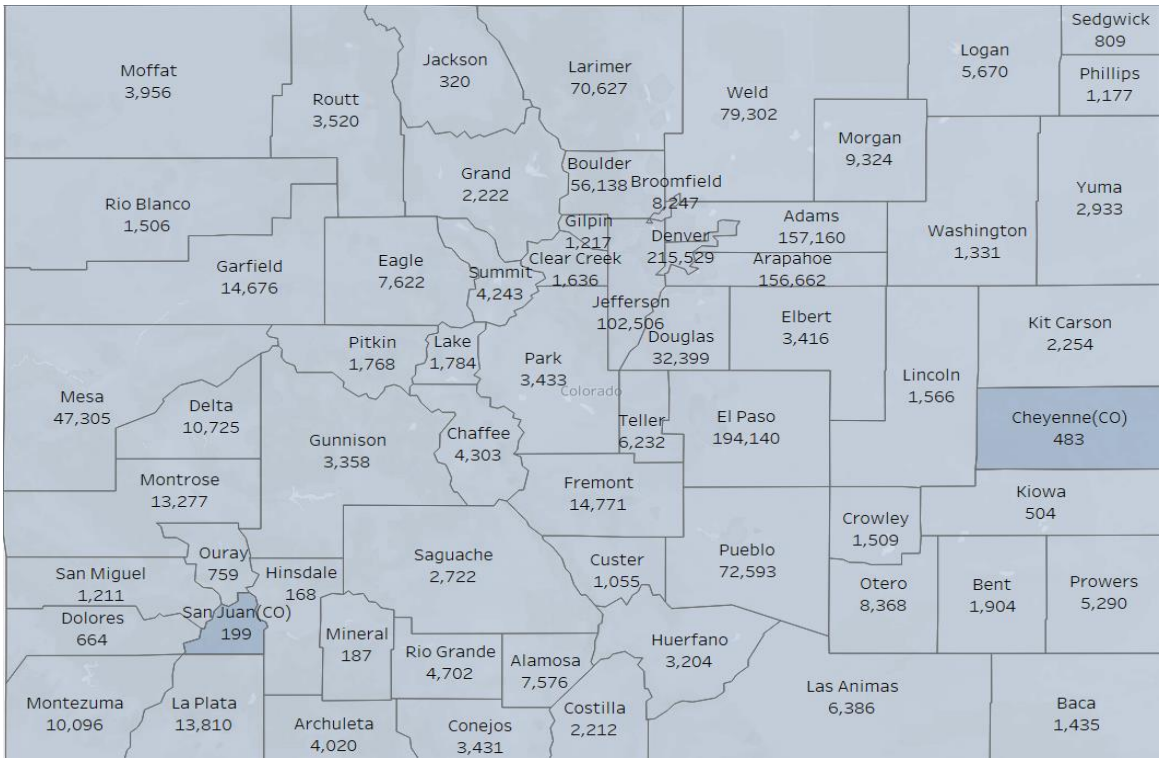




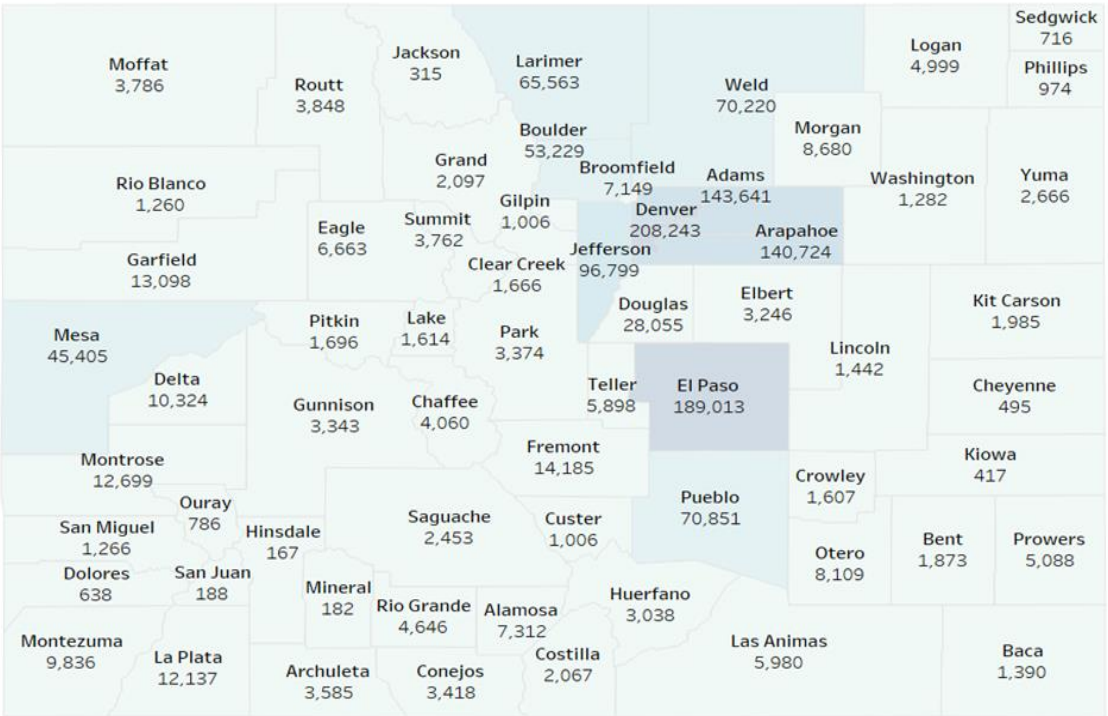
	2018	2019	2020
Multiple		503,381	578,340
White	454,758	394,147	519,812
Hispanic/Latino	366,887	150,991	89,422
Not Provided	162,998	100,341	71,128
Black/African American	95,790	61,362	86,468
Other/Unknown	183,281	21,541	15,439
Asian	31,453	19,759	28,971
American Indian/Alaska Native	21,878	8,545	11,288
Native Hawaiian/Other Pacific Islander	4,680	2,228	3,352



COUNTY MAP POPULATION 2020



COUNTY MAP POPULATION 2019



Enrollment and Disenrollment

In accordance with §438.56 the Department ensures enrollment and disenrollment services are compliant with federal and state regulations. The Department's Enrollment Broker strives to improve quality and efficiency of customer service for enrolling members by integrating technology in its processes and using data to increase efficiency and performance based on the identified performance measures.

Enrollment and Disenrollment Pay for Performance Metric 2020 Annual Average Rate are as follows:

Metric	Metric Definition and Measurement	2020 Annual Average
Enrollment and Disenrollment Error Rate	Performance Standard: ≥ 98% tasks/errors resolved monthly that impact the member's effective enrollment.	99.23%
Website Accuracy Rate	Performance Standard: ≥95% Website Accuracy Rate calculated on a monthly basis	98.40%
Enrollment Activities Audit	Measurement: The Enrollment Activities Audit shall be delivered to the Department in the agreed-upon format by the 15th day of the month immediately following the end of each month audited.	100.00%
Health Needs Survey Transmission Log	Health Needs Transmission Log shall be delivered to State monthly by the 15th day of each month after the end of each month for which the report covers.	100.00%
Member Satisfaction Rate	Performance Standard: Member Satisfaction Rate ≥ 85% 85% = 1%; 86% = 2%; 87% = 3%; 90% = 4% payment allowance for each percentage point above 84.9% on the member satisfaction score achieved in a month.	91.50%
Call Abandonment Rate	Performance Standard: Monthly abandonment rate of ≤ 5%. Monthly Abandonment rate of ≤ 4% or less shall result in an incentive payment.	0.38%
Average Speed of Answer	Performance Standard: Average monthly call wait time ≤120 **seconds**. Average monthly call wait time ≤ 90 **seconds** or less will result in an incentive payment.	24.42 Seconds
Calls on Hold Percent	Performance Standard: ≥90% of callers are placed on hold ≤ three (3) minutes. The related SOP shall be updated for agents to check back with a caller on hold at least every three (3) minutes.	91.56%
Post-Call Resolution Rate (3 Business Days) Post-call Resolution Rate (<30 Business Days)	Performance Standard: Post-call resolution rate ≥ 90% customer inquiries resolved ≤ three (3) business days; 100% ≤ 30 business days (unless Department resolution is required)	99.91%
Caller Delay Time	Performance Standard**: Count of calls answered </= ten (10) minutes / total calls answered is 97%.**	91.00%
Average QA Score	Definition: . The average score across all staff (receiving calls) during the reporting month 95%.	98.08%
Mailing Activity Timeliness	Measurement: (Pass / Fail) The Mailing Activity Report shall be delivered to the Department by the 15th business day of the month after the end of each calendar reporting month. SOPs updated.	100.00%

The Department achieved and/or exceeded all Enrollment and Disenrollment Pay for Performance Metrics for CY 2020

Reducing Disparities in Health Care

The Department's person-centered work has always prioritized awareness and recognition of the impacts of social determinants of health on outcomes for the culturally diverse communities our programs serve. Department workgroups have prioritized data collection to address racial health disparities related to maternal and infant health and diabetes care. The Department is developing an internal plan to address health disparities. Addressing health care disparities first requires the ability to accurately measure where a health disparity exists.

The Department is addressing health care disparities by refining data collection and systems on member and provider demographics, particularly race and ethnicity. This approach allows the Department and researchers to better disentangle factors that are associated with health care disparities. Further, collecting and analyzing patterns of health care by patient race, ethnicity, and other demographic data can help the Department to monitor the quality of care provided by its provider network. Such monitoring ensures accountability to enrolled members, improve member choice, and allow for evaluation of intervention programs. Focusing on data equity enables the Department to condition value-based payments to providers on evidence that they are improving health outcomes where disparities currently exist and enable new quality measurement that better allows the Department and providers to improve health disparities. Specifically, the Department seeks to:

- Address gaps in Medicaid application and claims data collection and analysis.
- Collect and analyze racial and ethnic disparities data from provider electronic health records systems (EHR), which includes information on clinical data and social determinants of health, such as food insecurity and housing.
- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.
- Enhance internal data analytics and health equity capacity to guide equity-focused, data-informed and evidence-based programmatic interventions to improve health outcomes for marginalized and underserved communities.
- Develop and implement health equity lens or framework to evaluate the Department's policies, systems, programs and services.

The Department has already initiated conversations with both of Colorado's Health Information Exchange (HIE) organizations – Colorado Regional Health Information Organization and Quality Health Network (QHN) on the western slope – and they are providing the Department with options to merge their demographic data with our Medicaid data. The Department is beginning similar conversations with the state's All Payers Claims Database (APCD) and the Department of Public Health and

Environment (CDPHE). By leveraging all available data sources, we can expand the Department's demographic markers, the accuracy of measuring where health disparities exist, and cause the potential solutions to increase.

The Department is uniquely positioned to incentivize Medicaid providers to capture demographic and clinical information from their patients and to build the interfaces to collect the data. The Department invests in HIE infrastructure that allows Medicaid providers and hospitals to securely connect their individual EHR systems with other systems through the health information exchange network.

Using enhanced federal funding, the Department has overseen the connection of over 300 clinics and 90 hospitals' electronic health records (EHRs) to Colorado's HIE organizations which cover over 6,300 providers and more than 6.5 million patients (including out-of-state visitors). The Department seeks to maintain these funds to continue connecting providers to the HIE and maintain this flow of information. Further, the Department can leverage enhanced federal funding to establish regular data feeds with these external databases to integrate demographic data into the Department's existing data warehouse. Once the data feeds and processes for merging data have been established, the same process can be duplicated so demographic data in the state's APCD can be expanded. That larger data set can be leveraged to address health care disparities statewide, beyond Medicaid.

Advancing Health Equity at the Department

The Department's approach to addressing health disparities is anchored in the tenet of ensuring high quality care and services for the people Medicaid serves. Our role as the Medicaid payer in Colorado's health care ecosystem affords the Department the lever to maximize health care investments in underserved and underrepresented communities by working collaboratively with partners to identify and remove obstacles to access and utilization among historically marginalized populations.

In accordance with the Governor Polis' Executive Order D2020-175, the Department is developing an Equity, Diversity, and Inclusion Plan that explicitly addresses nine EDI topic areas. Topic areas pertaining to health equity are highlighted below.

Long-Term Plan and Reporting. To create and continuously update a long-term plan to identify and address barriers as well as metrics to evaluate progress, Department activities will focus on:

- Convening an internal, employee-led workgroup dedicated to advancing health equity among Colorado Medicaid members.
- Developing a health equity lens or framework to guide decision-making across the Department.

Community Engagement. This topic area calls upon agencies to involve community partners in decision-making from the beginning to end of projects, as well as measuring equity, diversity and inclusion efforts on state boards and commissions appointed by the Governor's Office. In our focus on health equity, the Department intends to engage with Medicaid stakeholders and partners by:

- Cultivating meaningful and respectful dialogue on equity and diversity issues with

Medicaid members, providers, advocacy groups and other stakeholders
    - Engaging member and provider advisory groups in the work of health equity
- Allowing space for regional or geographic differences in defining diversity and equitable health outcomes for diverse Colorado communities
- Intentionally seek feedback from stakeholders about the emerging Department health equity lens or framework

Policy, System, Program, and Services Review. To abide by the expectation that agencies shall review, acknowledge, and dismantle any inequities within agency policies, systems, programs, and services, and continually update and report agency progress, the Department's health equity work will be guided by a focus on data analytics for the Medicaid population to include:

- Identify disparities data among marginalized, underrepresented and underserved communities across the state.
    - *Examples:* racial and ethnic disparities in Medicaid enrollment, primary care utilization, emergency department admissions, specific diagnostic and treatment codes.
    - data challenges from Medicaid claims data, as well as electronic health records systems (e.g., gaps in self-reported data).
- Data analytics will focus on ability, race and ethnicity, gender, language, national origin, sexual orientation, and other protected classes.
    - Highlight a focus on intersectionality, for example, specific health disparities linked to race and gender; ability and gender; language and race.
- Acknowledge different conceptualizations of diversity by region and/or geography.
- Identify and incorporate Medicaid health disparities data into key dashboards and/or develop a health equity-focused data dashboard.

Alignment with CDPHE's Health Equity Efforts. The Department's efforts to address health disparities and advance equity, diversity, and inclusion are aligned with equity-focused guidelines and principles championed by the Colorado Equity Alliance, a cross-agency group founded by staff of the CDPHE's Office of Health Equity. The alliance, comprised of representatives from both state agencies and community organizations, aims to operationalize equity and make sure it is woven into the fabric of state governance. The Department is represented in the core committee of the Colorado Equity Alliance. The CDPHE's Health Disparities Program is focused on preventing targeted conditions (e.g., cancer, cardiovascular/pulmonary disease) through upstream investments in social determinants such as housing.

National Performance Measures
§438.204(c)

At this time, Centers for Medicare and Medicaid Services (CMS) has not identified any required national performance measures. However, CMS has developed a voluntary set of core performance measures for children and adults in Medicaid and CHIP. Many of these measures have already been in

widespread use as part of the Healthcare Effectiveness Data and Information Set (HEDIS)® and have readily available national and regional benchmarks.

The Department reviews and selects HEDIS® measures for reporting each year to evaluate performance in terms of clinical quality and customer service. Measures are identified and selected annually using input from Department contractors, the External Quality Review Organization (EQRO), and Department staff. The Department is currently working to implement software that will enable HEDIS® reporting for the entire Health First Colorado population. Although CMS has not identified a list of required national performance measures, the Department has voluntarily reported a subset of the Adult and Child Core Set Measures to CMS annually. For calendar year 2019 the Department elected not to submit voluntary Adult and Child Core Set Measures due to a system conversion, which created data integrity issues. The Department continues to identify areas of opportunity for driving performance improvement and will report a select set of the CMS Adult and Child Core Measures in relation to identified national benchmarks in calendar year 2020. The Department strategically focused in on key deliverable effectiveness and assessment performance measures for calendar year 2020: Well-Child Visits, Screenings, Contraceptive Care, and Adolescents. Performance results are as follows:

Well-Care

Well-Care Visits	2019 (CY2018) Performance	2020 (CY2019) Performance	Median Performance (CMS SCORECARD)
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	53.00%	45.87% ↓	69.0%
Well-Child Visits in the First 15 Months of Life	39.90%	40.53% ↑	64.0%
Adolescent Well-Care Visits: Ages 12 to 21	31.00%	27.92% ↓	50.60%

↑ Indicates an increase ↓ Indicates a decrease

Well-child visits are critical checkpoints to assess the health and development of pediatric members throughout their early years and into adolescence. The Department is using its underperformance in this area as an opportunity to do an in-depth review of the reasons non-compliant members are not making these visits. One piece of this effort will be around provider education. The Department is also including these measures in its 2021 Primary Care APM to incentivize providers to focus on this area of preventive care.

Screenings

Screenings	2019 (CY2018) Performance	2020 (CY2019) Performance	Median Performance (CMS SCORECARD)
Breast Cancer Screening: Ages 50 to 74	37.10%	32.98% ↓	53.40%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications: Ages 18 to 64	83%	80.26% ↓	79.80%

↓ Indicates a decrease

Colorado's performance on screening measures highlights an area of opportunity in its quality strategy to integrate new data sources for tracking performance. Currently, information on breast screening for ages 50 to 74 is available through chart audits and is incomplete due to lookback periods and eligibility churn. The Department is working on a solution to integrate clinical data from electronic medical records with our partners to give us the needed information to complete this data set. Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications has been a consistent bright spot in the area of screening.

Contraceptive Care

Contraceptive Care	2019 (CY2018) Performance	2020 (CY2019) Performance	Median Performance (CMS SCORECARD)
Contraceptive Care: Postpartum Women Ages 21 to 44 - Most Effective or Moderately Effective Method of Contraception within 60 days of Delivery	38.60%	40.33%	40.20%
Contraceptive Care: All Women Ages 15 to 20 -Most Effective or Moderately Effective Method	28.30%	30.23% ↑	29.50%

↑ Indicates an increase

The Department's focus on contraceptive care has yielded positive results. Contraceptive care is a measure in multiple efforts including the ACC Performance Pool, the Maternity Condition Management Program, Maternity Value Based Payment Program, and the Hospital Transformation Program. In addition, contraceptive measures are being reviewed to be added to the APM in Program Year 2022.

Immunizations

Immunizations	2019 (CY2018) Performance	2020 (CY2019) Performance	Median Performance (CMS SCORECARD)
Childhood Immunization Status: Combo 3 by Age 2	22.10%	55.84%↑	68.80%
Immunizations for Adolescents: HPV Series by Age 13	20.20%	37.99%↑	34.40%

↑ Indicates and increase

The Department's efforts to integrate new data feeds into its quality performance measurement are highlighted in its immunization measure tracking. For 2020 reporting, the Colorado Immunization Registry data supplemented the Colorado claims data, which showed an improvement into the data. The childhood immunization status combo 3 by age 2 is now within reach of the CMS scorecard median performance. In 2020, the HPV series for adolescents has surpassed the median performance. These improvements in measurement are the result of improved feeds from the Colorado Immunization Information System. This data feed is an evolving data source for the Department and will be essential for measurement as immunization measures are included in the 2021 Primary Care APM.

Monitoring and Compliance
§438.204(b)(3)

Primary Care Alternative Payment Model

One of the primary objectives of the ACC is to ensure greater accountability and transparency. One way the Department looks to increase the transparency of the ACC is to share data on clinical and utilization measures used to monitor the program and its vendors. In addition, the Department shares data on social determinants of health metrics to highlight the roles Regional Accountable Entities (RAEs) play in supporting overall population health. These measures are important for tracking utilization of services and access to care.

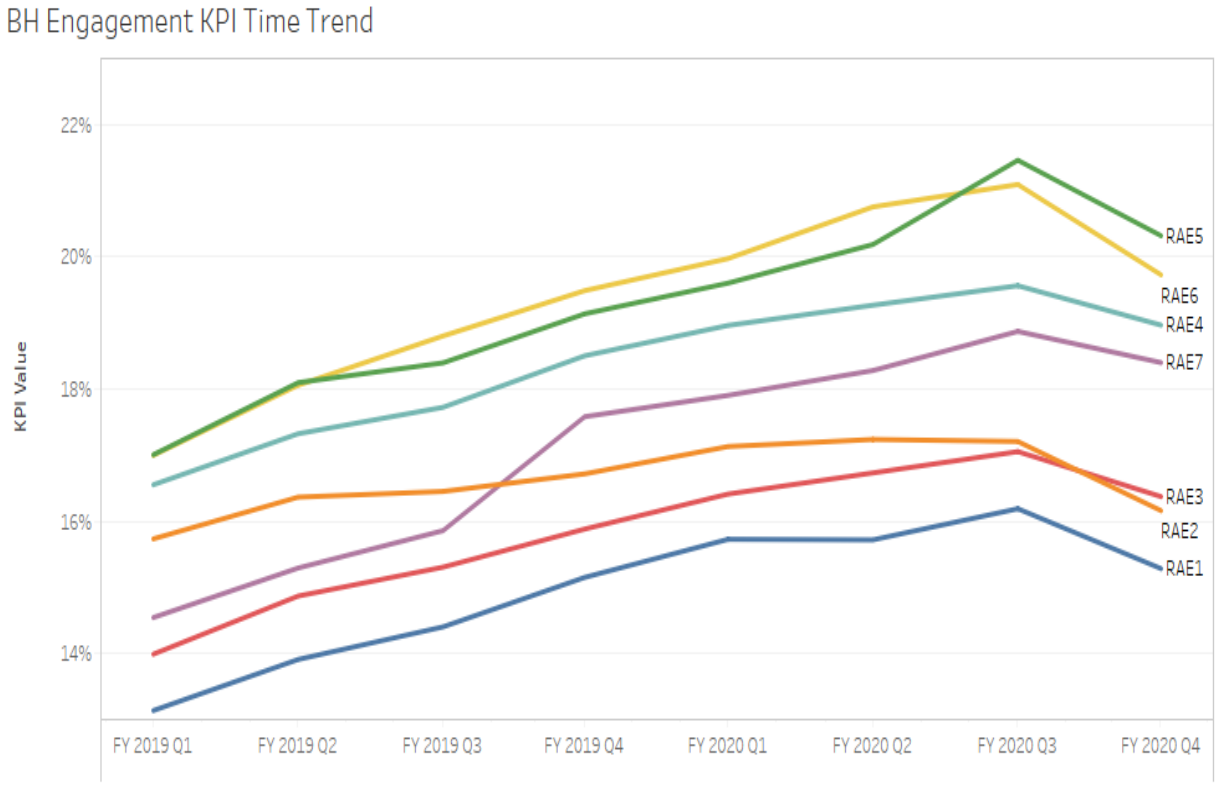
The public reporting dashboard is designed to help the RAEs identify the health needs of their members on a population level and provide stakeholders with a means to hold the RAEs accountable for performance and quality improvement.

Annual public reporting of performance measures can be accessed at:
https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-public-reporting.

Key Performance Indicators (KPI's)

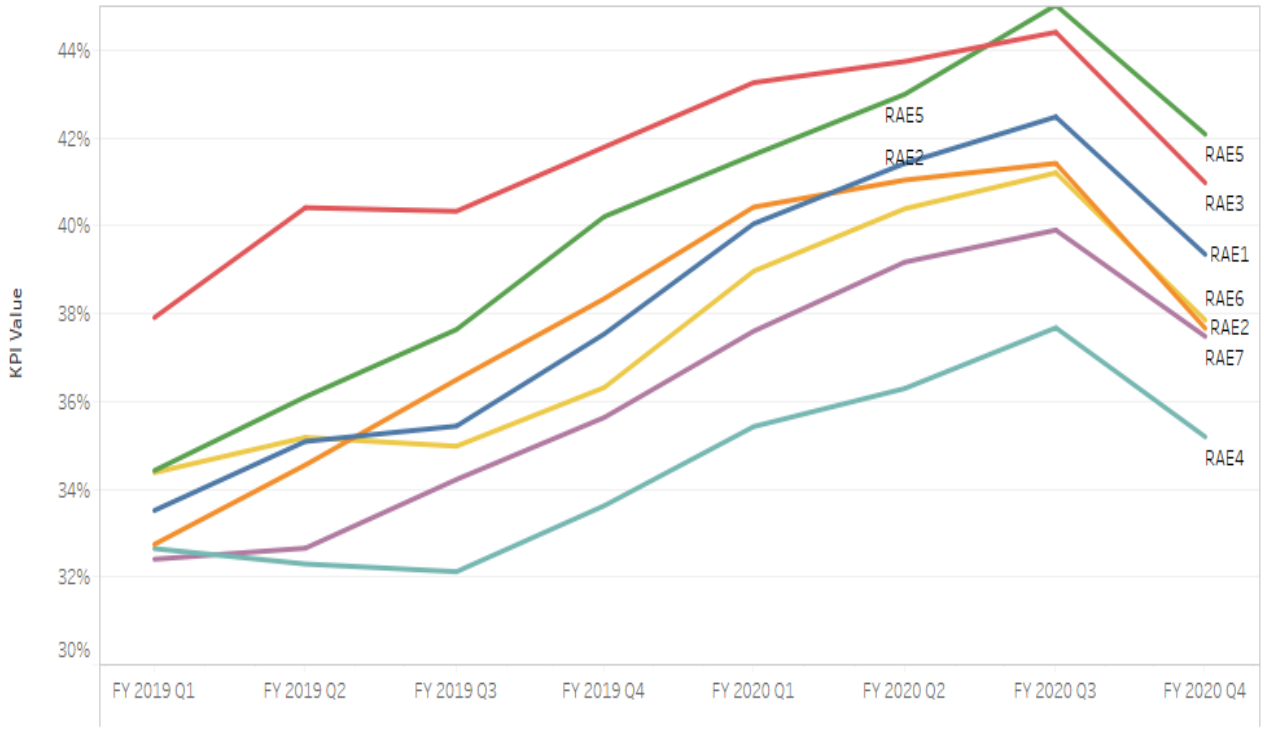
One of the primary objectives of the Department is to ensure greater accountability and transparency by sharing data on clinical and utilization measures that are used to monitor the ACC program and its vendors. Since the initiation of the ACC Program, the Department has made incentive payments for the performance on identified Key Performance Indicators (KPIs) to signal program-level goals and

objectives; encourage improved performance at the PCMP and regional level; and reward RAE and managed care entities for meeting certain levels of performance. For FY 2020-2021 the Department focused on the following KPI's to assess the RAEs progress in building a coordinated, community-based approach for serving the needs of Health First Colorado Members while reducing costs and promoting the health and wellbeing within their respective regions. Each KPI calculation is based on the utilization of services by the population enrolled in the ACC. FY 2020-2021 calculations are as follows:



	FY 2019				FY 2020					Target Met
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	BH Baseline	Met Target Tier 2
RAE1	13.14%	13.91%	14.40%	15.15%	15.73%	15.72%	16.19%	15.28%	11.94%	
RAE2	15.73%	16.37%	16.45%	16.72%	17.13%	17.24%	17.21%	16.16%	14.68%	
RAE3	13.99%	14.87%	15.31%	15.88%	16.41%	16.73%	17.05%	16.37%	12.87%	
RAE4	16.55%	17.32%	17.72%	18.50%	18.96%	19.27%	19.56%	18.97%	15.70%	
RAE5	17.01%	18.10%	18.40%	19.14%	19.60%	20.19%	21.46%	20.32%	15.84%	
RAE6	17.00%	18.06%	18.80%	19.49%	19.97%	20.76%	21.09%	19.73%	15.45%	
RAE7	14.54%	15.29%	15.86%	17.58%	17.90%	18.28%	18.87%	18.40%	13.01%	

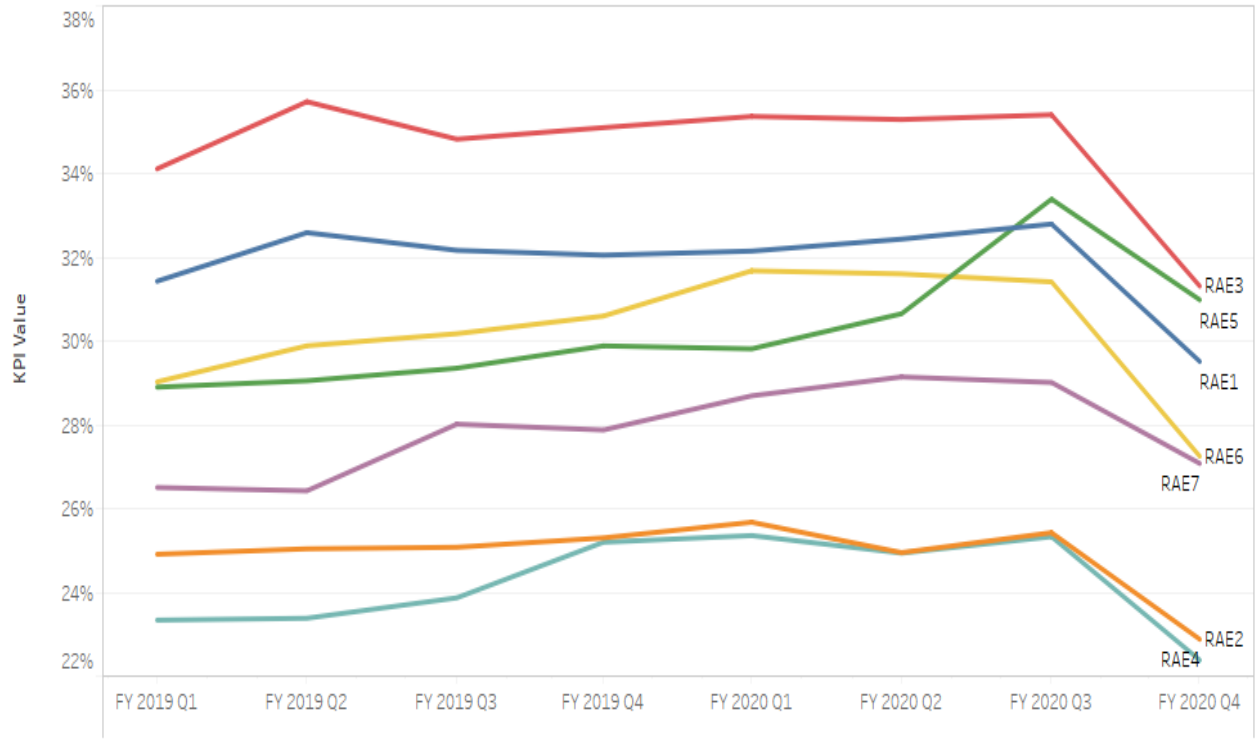
Dental Visits KPI Time Trend



	FY 2019				FY 2020				Dental Visits Baseline
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
RAE1	33.52%	35.09%	35.44%	37.53%	40.05%	41.42%	42.48%	39.35%	33.38%
RAE2	32.74%	34.55%	36.49%	38.34%	40.42%	41.04%	41.42%	37.66%	32.47%
RAE3	37.91%	40.41%	40.33%	41.79%	43.26%	43.74%	44.41%	40.98%	37.61%
RAE4	32.65%	32.30%	32.12%	33.62%	35.43%	36.29%	37.68%	35.19%	32.26%
RAE5	34.42%	36.10%	37.64%	40.21%	41.62%	42.99%	45.02%	42.08%	33.62%
RAE6	34.38%	35.18%	34.98%	36.32%	38.97%	40.39%	41.20%	37.85%	34.56%
RAE7	32.41%	32.66%	34.22%	35.63%	37.60%	39.17%	39.90%	37.48%	32.94%

Target Met
- Met Target Tier 1
- Met Target Tier 2
- No Target Met

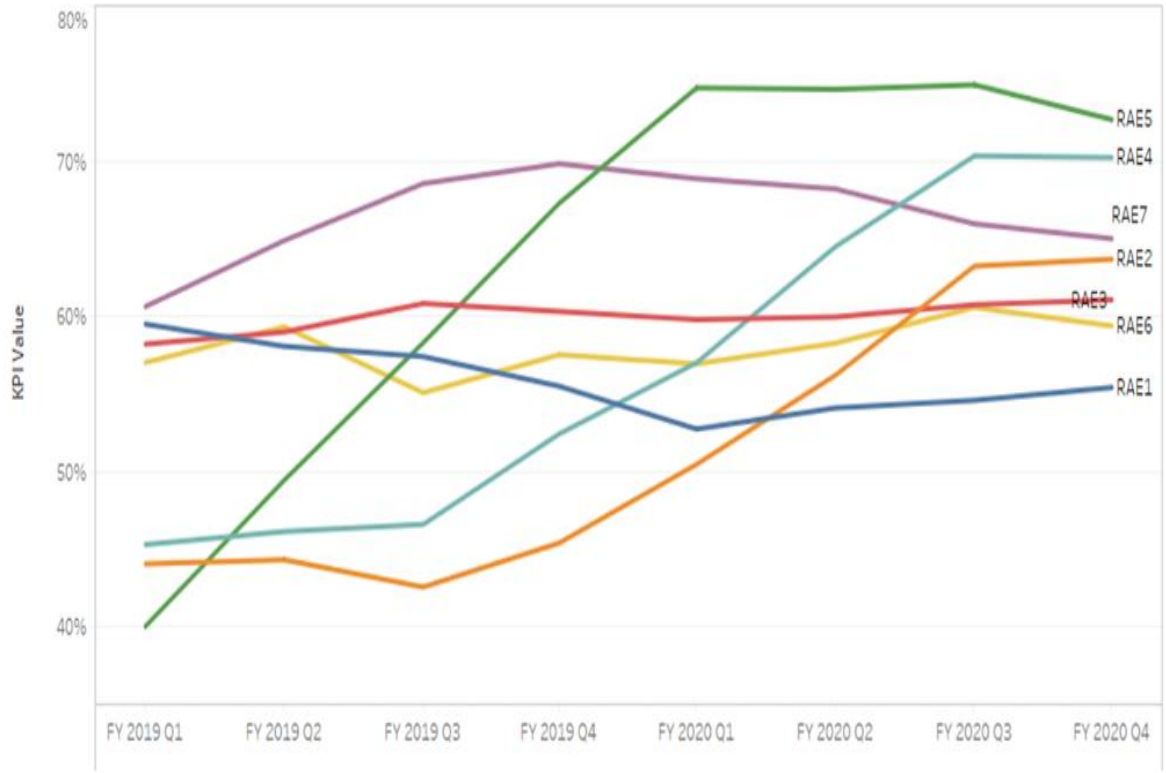
Well Visits KPI Time Trend



	FY 2019				FY 2020				Well Visits Baseline
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
RAE1	31.43%	32.59%	32.17%	32.05%	32.15%	32.43%	32.79%	29.51%	31.33%
RAE2	24.91%	25.04%	25.08%	25.30%	25.67%	24.95%	25.43%	22.88%	25.38%
RAE3	34.11%	35.71%	34.82%	35.10%	35.36%	35.29%	35.40%	31.31%	34.36%
RAE4	23.34%	23.38%	23.87%	25.20%	25.36%	24.94%	25.33%	22.38%	23.08%
RAE5	28.90%	29.05%	29.35%	29.88%	29.81%	30.65%	33.39%	30.98%	29.83%
RAE6	29.03%	29.89%	30.18%	30.60%	31.68%	31.60%	31.41%	27.25%	29.22%
RAE7	26.50%	26.42%	28.02%	27.88%	28.69%	29.14%	29.01%	27.08%	27.20%

Target Met
- Met Target Tier 2
- Met Target Tier 1
- No Target Met

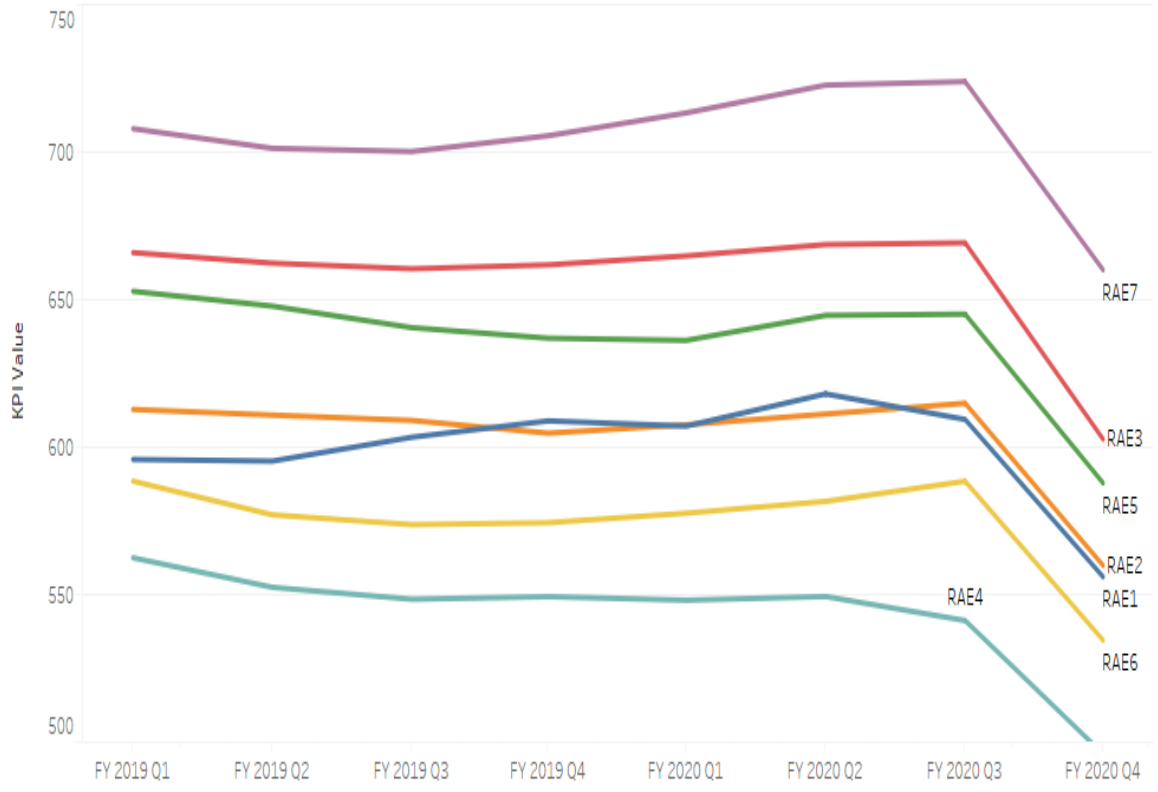
Prenatal KPI Time Trend



	FY 2019				FY 2020				
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Prenatal Visits Baseline
RAE1	59.50%	58.07%	57.40%	55.50%	52.74%	54.10%	54.59%	55.42%	60.19%
RAE2	44.05%	44.32%	42.56%	45.40%	50.47%	56.21%	63.23%	63.67%	42.96%
RAE3	58.21%	58.99%	60.82%	60.31%	59.78%	59.96%	60.74%	61.06%	57.58%
RAE4	45.30%	46.14%	46.60%	52.42%	57.01%	64.49%	70.33%	70.22%	41.82%
RAE5	40.03%	49.45%	58.30%	67.28%	74.70%	74.62%	74.91%	72.67%	38.15%
RAE6	57.02%	59.32%	55.08%	57.52%	56.94%	58.27%	60.58%	59.38%	55.64%
RAE7	60.63%	64.88%	68.55%	69.82%	68.86%	68.20%	65.95%	65.00%	54.26%

Target Met
- Met Target Tier 2
- Met Target Tier 1
- No Target Met

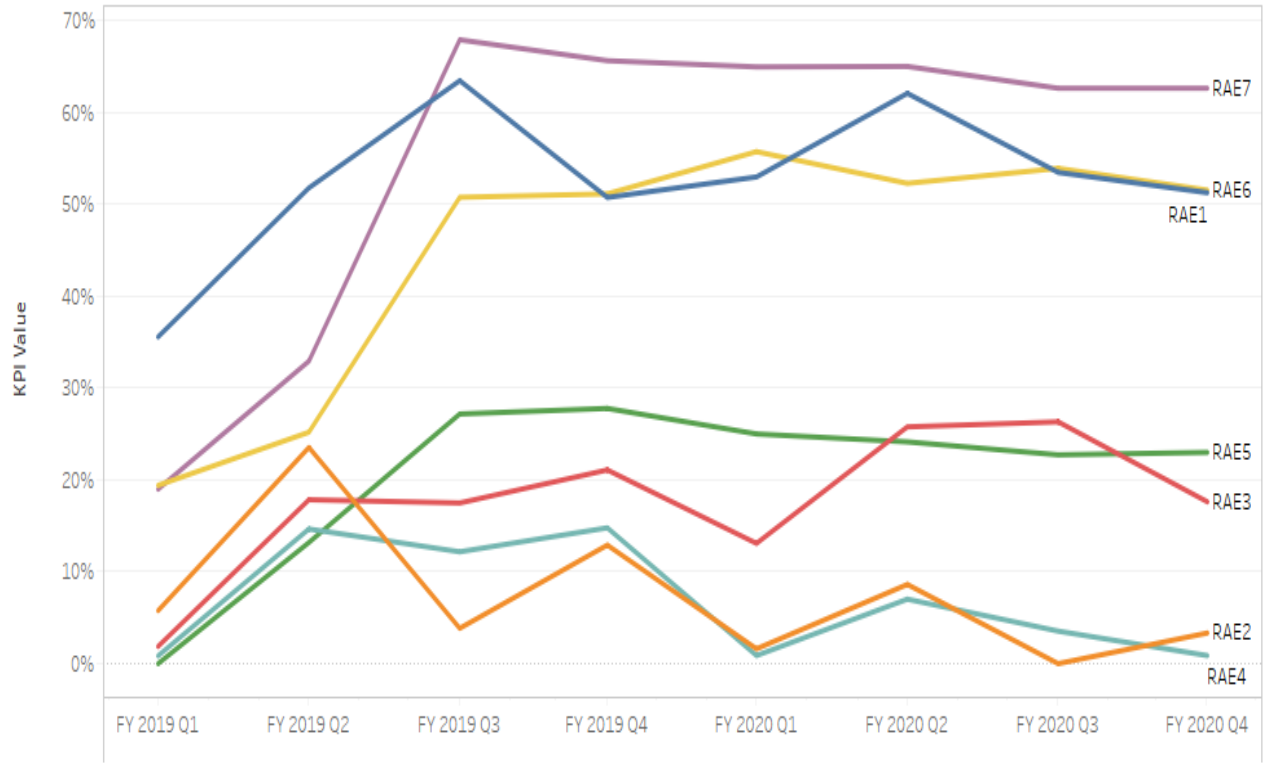
Risk Adjusted ED Visits PKPY KPI Time Trend



	FY 2019				FY 2020				Risk Adjusted ED PKPY Baseline
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
RAE1	595.9	595.3	603.4	608.9	607.2	618.1	609.4	556.1	597.4
RAE2	612.8	610.9	609.1	604.8	607.6	611.6	614.9	559.9	620.4
RAE3	665.9	662.4	660.5	661.8	664.8	668.7	669.3	602.7	661.5
RAE4	562.5	552.5	548.5	549.4	548.2	549.4	541.3	496.1	571.6
RAE5	652.8	647.8	640.5	636.9	636.2	644.7	645.1	587.9	647.5
RAE6	588.5	577.1	573.8	574.4	577.6	581.6	588.5	534.6	585.7
RAE7	708.0	701.3	700.2	705.6	713.3	722.7	723.9	660.1	700.3

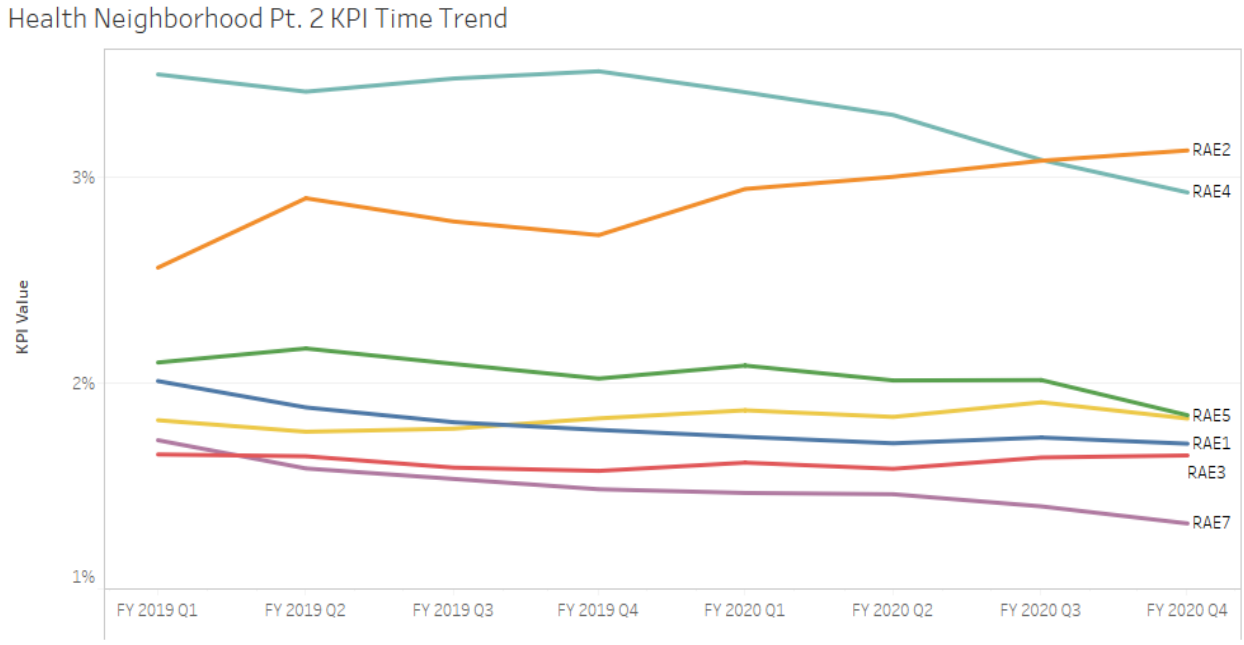
Target Met
- Met Target Tier 1
- Met Target Tier 2
- No Target Met

Health Neighborhood pt. 1 KPI Time Trend



	FY 2019				FY 2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
RAE1	35.57%	51.78%	63.45%	50.74%	52.97%	62.07%	53.47%	51.26%
RAE2	5.77%	23.53%	3.85%	12.90%	1.61%	8.62%	0.00%	3.33%
RAE3	1.88%	17.84%	17.49%	21.08%	13.09%	25.77%	26.32%	17.62%
RAE4	0.85%	14.66%	12.17%	14.78%	0.88%	7.02%	3.54%	0.88%
RAE5	0.00%	13.19%	27.17%	27.78%	25.00%	24.14%	22.73%	22.99%
RAE6	19.40%	25.19%	50.76%	51.13%	55.73%	52.27%	53.91%	51.54%
RAE7	18.99%	32.93%	67.90%	65.63%	64.95%	65.00%	62.63%	62.63%

Target Met
Met Target
No Target Met



	FY 2019 Q1	FY 2019 Q2	FY 2019 Q3	FY 2019 Q4	FY 2020 Q1	FY 2020 Q2	FY 2020 Q3	FY 2020 Q4	HN pt. 2 Baseline
RAE1	2.01%	1.88%	1.81%	1.77%	1.74%	1.71%	1.74%	1.71%	2.10%
RAE2	2.56%	2.90%	2.78%	2.72%	2.94%	3.00%	3.08%	3.13%	2.55%
RAE3	1.65%	1.64%	1.59%	1.57%	1.61%	1.58%	1.64%	1.65%	1.72%
RAE4	3.50%	3.41%	3.48%	3.51%	3.41%	3.30%	3.08%	2.92%	3.52%
RAE5	2.10%	2.17%	2.09%	2.02%	2.08%	2.01%	2.01%	1.84%	2.29%
RAE6	1.82%	1.76%	1.78%	1.83%	1.87%	1.84%	1.91%	1.83%	1.94%
RAE7	1.72%	1.59%	1.53%	1.48%	1.47%	1.46%	1.40%	1.32%	1.86%

Target Met
Met Target Tier 2
No Target Met

Member Experience Surveys

Consumer Assessment of Health Providers and Systems (CAHPS)

The CAHPS surveys ask members questions about the service provided by their health plans. Results are used to inform health plans about how satisfied members are with the care they receive and where they need to improve.

Figure 3 shows the FY 2018–2019 and FY 2019–2020 Colorado RAE Aggregate (i.e., statewide average) Patient-Centered Medical Home (PCMH) CAHPS survey results for PCMH practices serving children within the seven RAEs

Figure 3
PCMH CAHPS – Adult Statewide PCMH CAHPS Results for RAEs

Measure	FY 2018–2019 Colorado RAE Aggregate	FY 2019–2020 Colorado RAE Aggregate
Rating of Provider	63.6%	59.1%
Rating of Specialist Seen Most Often	62.3%	63.7%
Rating of All Health Care	59.1%	55.8%
Rating of Health Plan	60.3%	61.3%
Getting Timely Appointments, Care, and Information	47.7%	44.6%
How Well Providers Communicate with Patients	73.9%	71.4%
Providers' Use of Information to Coordinate Patient Care	61.8%	58.7%
Talking with You About Taking Care of Your Own Health	48.9%	48.0%
Comprehensiveness	52.8%	51.0%
Helpful, Courteous, and Respectful Office Staff	69.1%	68.6%
Health First Colorado Customer Service	62.6%	63.5%
Received Care from Provider Office During Evenings, Weekends, or Holidays	27.3%	23.2%
Reminders about Care from Provider Office	71.6%	71.0%
Saw Provider Within 15 Minutes of Appointment	38.4%	38.0%
Receive Health Care and Mental Health Care at Same Place	57.6%	60.4%

**Results from the survey do not directly assess RAE performance, as the survey questions ask about a member's experiences with a provider at a specific practice.*

**Results from the survey do not directly assess RAE performance, as the survey questions ask about a member's experience with a provider at a specific practice.*

Due to differences in selected practices, the FY 2019–2020 Colorado RAE Aggregate results presented in this report are not comparable to the FY 2018–2019 Colorado RAE Aggregate results.

Figure 4
PCMH CAHPS-Child Statewide PCMH CAHPS Results for RAEs*

Measure	FY 2018–2019 Colorado RAE Aggregate	FY 2019–2020 Colorado RAE Aggregate
Rating of Provider	76.0%	71.8%
Rating of Specialist Seen Most Often	74.0%	78.0%
Rating of All Health Care	74.3%	72.0%
Getting Timely Appointments, Care, and Information	66.2%	57.3%
How Well Providers Communicate with Child	80.6%	79.3%
How Well Providers Communicate with Parents or Caretakers	81.9%	78.3%
Providers' Use of Information to Coordinate Patient Care	74.7%	70.7%
Comprehensiveness—Child Development	65.7%	65.5%
Comprehensiveness—Child Safety and Healthy Lifestyles	58.2%	61.0%
Helpful, Courteous, and Respectful Office Staff	69.3%	65.0%
Received Information on Evening, Weekend, or Holiday Care	80.9%	78.6%
Received Care from Provider Office During Evenings, Weekends, or Holidays	32.1%	33.1%
Saw Provider Within 15 Minutes of Appointment	42.1%	36.6%
Reminders about Child's Care from Provider Office	67.9%	69.1%

**Results from the survey do not directly assess RAE performance, as the survey questions ask about a parent's/caretaker's experiences with the child's provider at a specific practice.*

Due to differences in selected practices, the FY 2019–2020 Colorado RAE Aggregate results presented in this report are not comparable to the FY 2018–2019 Colorado RAE Aggregate results.

Adult

For the adult population, the following three measures had the lowest FY 2019–2020 scores compared to the other measures' scores:

- Received Care from Provider Office During Evenings, Weekends, or Holidays (23.2 percent)
- Saw Provider Within 15 Minutes of Appointment (38.0 percent)
- Getting Timely Appointments, Care, and Information (44.6 percent)

Child

For the child population, the following three measures had the lowest FY 2019–2020 scores compared to the other measures' scores:

- Received Care from Provider Office During Evenings, Weekends, or Holidays (33.1 percent)
- Saw Provider Within 15 Minutes of Appointment (36.6 percent)
- Getting Timely Appointments, Care, and Information (57.3 percent)

The Department will continue to collaborate with the RAE's to develop statewide initiatives designed to improve access to and timeliness of care for adults and children enrolled in Medicaid.

CAHPS Surveys – MCO Capitation Initiative

Figure 5 shows the adult statewide CAHPS results for FY 2017–2018, FY 2018–2019, and FY 2019–2020.

Figure 5 – Adult Statewide CAHPS Results for MCOs

Measure	FY 2017–2018 Statewide Aggregate	FY 2018–2019 Statewide Aggregate	FY 2019–2020 Statewide Aggregate
Getting Needed Care	79.6%	76.9%	78.4%
Getting Care Quickly	81.2%	77.9%	77.2% ↓
How Well Doctors Communicate	92.3%	93.3%	93.9%
Customer Service	87.1%	91.6%	91.3%
Rating of Personal Doctor	70.0%	69.5%	71.7%
Rating of Specialist Seen Most Often	62.7%	70.2%	71.2%
Rating of All Health Care	56.0%	56.0%	56.7%
Rating of Health Plan	58.0%	61.6%	63.4%

↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

Figure 6 Shows the Child statewide CAHPS results for FY2017-2018, FY 2018-2019, and FY 2019-2020

Figure 6– Child Statewide CAHPS Results for MCO's

Measure	FY 2017–2018 Statewide Aggregate	FY 2018–2019 Statewide Aggregate	FY 2019–2020 Statewide Aggregate
Getting Needed Care	84.8%	78.3%	75.1%+
Getting Care Quickly	86.2%	87.2%	80.5%+ ↓
How Well Doctors Communicate	94.7%	95.4%	94.9%+
Customer Service	91.2%	86.1%	89.0%+
Rating of Personal Doctor	86.1%	85.8%	78.8%
Rating of Specialist Seen Most Often	75.0%+	75.7%+	60.9%+
Rating of All Health Care	76.7%	73.5%	66.0%+
Rating of Health Plan	76.9%	73.2%	67.4%

CAHPS scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a CAHPS measure, caution should be exercised when interpreting results.
↓ *Indicates the FY 2019–2020 score is statistically significantly below the 2019 NCQA national average.*

RMHP Prime was not required to submit child Medicaid CAHPS data for reporting purposes in FY 2019–2020; therefore, the FY 2019–2020 Statewide Aggregate only includes CAHPS results for DHMP and is not comparable to the FY 2017–2018 and FY 2018–2019 Statewide Aggregates.

For the adult statewide Medicaid population, overall, member experience scores for the MCOs' adult population have fluctuated, either increasing or decreasing slightly, across the years; however, there appears to be an upward trend (i.e., higher scores) for the How Well Doctors Communicate, Rating of Specialist Seen Most Often, and Rating of Health Plan measures and a downward trend (i.e., lower scores) for the Getting Care Quickly measure, which also scored statistically significantly below the 2019 NCQA adult Medicaid national average. The Department will continue to work with the MCOs to develop initiatives designed to improve timeliness of care.

For the child statewide Medicaid population, overall, member experience scores for the MCOs' child population have fluctuated, either increasing or decreasing slightly, across the years; however, there appears to be a downward trend for the Getting Needed Care, Rating of Personal Doctor, Rating of All Health Care, and Rating of Health Plan measures. The Department will continue to work with the MCOs to develop initiatives designed to improve timeliness of and access to care, communication, and coordination of care.

Figure 7
ECHO- Adult

Measure	FY 2018–2019 Colorado RAE Program	FY 2019–2020 Colorado RAE Program
Rating of All Counseling or Treatment	45.9%	46.4%
Getting Treatment Quickly	66.3%	68.8%
How Well Clinicians Communicate	89.0%	89.8%
Perceived Improvement	58.0%	59.9%
Amount Helped	80.5%	82.5%
Cultural Competency	66.5%+	69.2%+
Including Family	42.0%	43.9%
Information About Self-Help or Support Groups	52.6%	53.7%
Information to Manage Condition	76.3%	77.0%
Office Wait	81.5%	84.5%
Patient Feels He or She Could Refuse Treatment	82.8%	78.8%
Privacy	92.5%	94.7%
Support from Family and Friends	67.2%	62.5% ▼
Told About Medication Side Effects	74.8%	74.6%
Improved Functioning	54.9%	52.0%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.

▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

Figure 8
ECHO-Child

Measure	FY 2018–2019 Colorado RAE Program	FY 2019–2020 Colorado RAE Program
Rating of All Counseling or Treatment	46.5%	44.7%
Getting Treatment Quickly	69.8%	66.2%
How Well Clinicians Communicate	87.9%	88.1%
Perceived Improvement	70.7%	68.6%
Amount Helped	78.1%	75.2%
Child Had Someone to Talk To	77.3%	73.4%
Cultural Competency	60.8%+	71.8%+
Information to Manage Condition	70.8%	70.9%
Office Wait	84.9%	89.7% ▲
Privacy	94.0%	94.7%
Respondent Feels He or She Could Refuse Treatment	85.3%	88.8%
Support from Family and Friends	80.7%	69.7% ▼
Told About Medication Side Effects	85.2%	84.3%
Improved Functioning	63.0%	60.3%

Scores with fewer than 100 respondents are denoted with a cross (+). In cases of fewer than 100 respondents for a measure, caution should be exercised when interpreting results.
▲ *Indicates the FY 2019–2020 score is statistically significantly higher than the FY 2018–2019 score.*
▼ *Indicates the FY 2019–2020 score is statistically significantly lower than the FY 2018–2019 score.*

For the child population, the Colorado RAE Program scored statistically significantly higher in FY 2019–2020 than in FY 2018–2019 for one measure, Office Wait. For the adult and child populations, the Colorado RAE Program scored statistically significantly lower in FY 2019–2020 than in FY 2018–2019 for one measure, Support from Family and Friends. The Department will continue to work with the RAEs to explore what may be driving a statistically significantly lower experience score for this measure and to develop statewide initiatives for improvement, where appropriate.

Due to cost reductions, administration of the Department transitioned the ECHO survey over to the Office of Behavioral Health Effective FY 2021 for future survey administration

National Core Indicators

Due to the COVID-19 global pandemic, declaration of a national public health emergency, and the need to avoid in-person contact, the Department had to prematurely end the 2019-2020 data collection cycle for the National Core Indicators' In-Person Survey. Anticipating continued challenges to direct-contact data collection in future cycles, The Department participated in a national ongoing pilot study to assess the feasibility of administering the survey through videoconference. As one of seven states participating in this pilot study, from May through July 2020, the Department sought to determine whether remote surveying results would be comparable to those from direct-contact surveys. The analysis revealed few differences between the two groups: they were similar in demographic characteristics, extent of disability, capacity for verbal communication, proxy use, and type of community (i.e., level of rurality). The few statistically significant differences indicate that remote

participants were more likely to be physically active, to have a legal guardian, and to have higher scores on a scale that measures the level of personal choice, and they were less likely to have a behavioral challenge. Even among the factors that showed statistically significant differences between the two groups, the differences were relatively small; their effects on the comparability of the two modes do not pose serious threats to the reliability of remote surveys. The similarity between the participants of remote and direct-contact surveys and their responses to the survey questions suggest that, with continued care and attention to surveyor training, revised protocols, and working to ensure access to remote technology for all those who want to participate, remote surveys are feasible and reliable. The Department recommends moving forward with the use of the videoconference survey option for the 2020-21 cycle.

Monitoring for Compliance with Federal Healthcare Regulations

The Department's comprehensive quality improvement program strives to incorporate all departmental operational areas to monitor and ensure compliance with all state and federal regulatory requirements. This includes a review of the health plan's documents (e.g., policies and procedures, operational reports, provider and informational materials) and a visit to the health plan's site to interview key staff members and review administration records.

Compliance Monitoring Areas of Review in FY 2019-2020

Evaluation and effectiveness of compliance with Medicaid managed care regulations was designed to determine the RAE's compliance with contracts with the department, state and federal managed care regulation and related Department contract requirements. The Department's compliance monitoring measures how well each health plan complied with federal healthcare regulations and met the requirements of their contract with the Department. Compliance monitoring includes a review of the health plan's documents (e.g., policies and procedures, operational reports, provider and informational materials) and a visit to the health plan's site to interview key staff members and review administration records. For FY 2019-2020 compliance monitoring focused on three (3) standard areas for each seven (7) RAE's and eleven (11) for two MCO's approved by the Department. FY 2019-2020 Statewide averages are listed below:

Figure 9 Statewide Compliance Monitoring Results – Statewide Performance for the RAEs

Standard	Statewide Average—FY 2019–2020
Standard I—Coverage and Authorization of Services	88%
Standard II—Access and Availability	97%
Standard VI—Grievance and Appeal Systems	79%

For the seven RAEs providing services under Colorado ACC Program, the health plans demonstrated high performance with Standard II- Access and Availability. Scores ranges from 94 to 100 percent

compliance, demonstrating the RAEs' ability to accurately understand requirements and implement procedures to demonstrate compliance. Scores for Standard I – Coverage and Authorization of Services ranged from 80 to 97 percent compliance, reflecting general compliance with regulations. Lastly, Standard VI- Grievance and Appeal Systems scores demonstrated an opportunity to improve RAE understanding of requirements related to this content area. Scores ranged from 71 to 86 percent compliant.

Figure 10 Statewide Compliance Monitoring Results -Statewide Trended Performance for the Two MCOs Included in the Capitated Managed Care Initiative

Standard and Applicable Review Years	Statewide Average—Previous Review	Statewide Average—Most Recent Review
Standard I—Coverage and Authorization of Services (2016–2017; 2019–2020)*	**94%**	**94%**
Standard II—Access and Availability (2016–2017, 2019–2020)*	**96%**	**94%**
Standard III—Coordination and Continuity of Care (2015–2016, 2018–2019)	96%	86%
Standard IV—Member Rights and Protections (2015–2016, 2018–2019)	90%	93%
Standard V—Member Information (2017–2018, 2018–2019)	85%	83%
Standard VI—Grievance and Appeal Systems (2017–2018, 2019–2020)*	**87%**	**86%**
Standard VII—Provider Participation and Program Integrity (2014–2015, 2017–2018)	97%	86%
Standard VIII—Credentialing and Recredentialing (2012–2013, 2015–2016)	97%	99%
Standard IX—Subcontracts and Delegation (2014–2015, 2017–2018)	100%	50%
Standard X—Quality Assessment and Performance Improvement (2012–2013, 2015–2016)	81%	94%
Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (2016–2017, 2018–2019)	77%	93%

*Bold text indicates standards that HSAG reviewed during FY 2019-2020

The statewide average scores (based on the two MCOs) demonstrated no improvement in scores during the most recent year of review for the three standards reviewed in FY 2019–2020. However, the statewide average score sustained overall high performance (above 90 percent) for Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. For Standard I—Coverage and Authorization of Services, the statewide average score remained stable at 94 percent.

The statewide average scores for both Standard II—Access and Availability and Standard VI—Grievance and Appeal Systems decreased slightly (9 percentage points or fewer) when compared to the previous year these standards were reviewed. When compared to previous review cycles, the most significant improvement (16 percentage points) was observed in Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) (reviewed last in FY 2018–2019) followed by an increase of 13 percentage points in Standard X—Quality Assessment and Performance Improvement. A slight increase (9 percentage points or fewer) was noted in Standard IV—Member Rights and Protections and Standard VIII—Credentialing and Recredentialing. Statewide MCO average performance declined in

four standards (Standard III—Coordination and Continuity of Care, Standard V—Member Information Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation) when compared to the previous review for those standards. The reader should consider these changes in performance between review cycles with caution as changes in federal regulations or in State contract requirements, and design of the compliance monitoring tool may have impacted comparability of the Compliance Monitoring results.

Figure 11 displays the statewide average Compliance Monitoring results for the most recent year that each standard area was reviewed. As FY 2019–2020 was the second year of RAE operations, no comparative statewide averages are available for the standards that will be reviewed in FY 2020–2021, the third year of compliance standard rotation for the RAEs.

Figure 11 Compliance with Regulations – Statewide Performance for the Seven RAEs

Standard and Applicable Review Years	Statewide Average
Standard I – Coverage and Authorization of Services (2019-2020) *	88%
Standard II – Access and Availability (2019-2020) *	97%
Standard III – Coordination and Continuity of Care (2018-2019)	95%
Standard IV – Member Rights and Protections (2018-2019)	98%
Standard V – Member Information (2018-2019)	92%
Standard VI – Grievance and Appeal Systems (2019-2020)	79%
Standard VII – Provider Participation and Program Integrity (not yet scored**)	NA**
Standard VIII – Credentialing and Recredentialing (not yet scored**)	NA**
Standard IX – Subcontracts and Delegation (not yet scored**)	NA**
Standard X – Quality Assessment and Performance Improvement (not yet scored**)	NA**
Standard XI – Early and Periodic Screening, Diagnostic, and Treatment Services (2018-2019)	88%

**Bold text indicates standards reviewed during FY 2019-2020*
***Not yet scored as the RAE contract did not begin until July 1, 2018*

In the second year of RAE operations, the Department reviewed three standard areas. The statewide average score in one of the three areas was over 90 percent compliant (Standard II—Access and Availability), indicating an understanding by the RAEs of most federal regulations related to this standard, and organizational processes are sufficient to implement those requirements. For Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems, scores indicate an opportunity to improve RAE understanding of federal and State requirements related to this content area.

While most health plans demonstrated high performance in Standard II—Access and Availability, one common area of opportunity was for health plans to improve provider monitoring and corrective actions, when needed to ensure provider compliance with access standards (time, distance, and provider ratio). In terms of Standard I—Coverage and Authorization of Services, overall scores were widely varied (80 to 97 percent), and many health plans were required to improve the accuracy of information sent to members and providers, as well as ensure member-specific communications are easy to read. Lastly, Standard VI—Grievance and Appeal Systems compliance scores were the lowest

across Medicaid health plans during the most recent review, with common opportunities surrounding accurate definitions, member and provider information, and member-friendly correspondence.

Validation of Performance Measures

- Performance Measures are rates that are designed to indicate how well a health plan is providing care and services. The measures used in Colorado are the same measures used throughout the country.
- The purpose of validating the Performance Measures is to ensure the data collected and outcomes reported are accurate and valid.

The Department evaluated the RAEs' accuracy of performance measure reporting and determined the extent to which the reported rates followed State specifications and reporting requirements. For the current reporting period, Health Services Advisory Group (HSAG) determined that the data collected and reported for the Department-selected measures by all seven RAEs followed State specifications and reporting requirements, and the rates were valid, reliable, and accurate.

The following Tables reflect FY 2019-20 performance measure results for the statewide average and the corresponding incentive performance targets for the RAEs. Cells shaded green indicate the statewide average's performance met or exceeded the FY 2019–2020 incentive performance target. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the incentive performance target are shaded green.

Figure 12 - Statewide BH PM Results – (RAEs) (Final Year)

Performance Measure	FY 2019–2020 Rate	Performance Target
Engagement in Outpatient Substance Use Disorder (SUD) Treatment		
Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.64%	51.22%
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition		
Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a Mental Health Condition	65.43%	81.51%
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)		
Follow-Up Within 7 Days of an Emergency Department (ED) Visit for Substance Use Disorder (SUD)	34.98%	49.69%
Follow-Up After a Positive Depression Screen		
Follow-Up After a Positive Depression Screen	50.16%	54.40%
Behavioral Health Screening or Assessment for Children in the Foster Care System		
Behavioral Health Screening or Assessment for Children in the Foster Care System	16.86%	37.96%

For performance measure validation, all RAEs had adequate processes in place regarding their eligibility and enrollment of members, how they processed claims and encounters, and how they integrated their data for the measures being calculated. Although the statewide average met none of the performance targets, four out of seven (57.1 percent) RAEs exceeded the statewide average for Engagement in Outpatient Substance Use Disorder (SUD) Treatment, three out of seven (42.9 percent) exceeded the statewide average for Follow-Up Within 7 Days of an Inpatient Hospital Discharge for a

Mental Health Condition, and five out of seven (71.4 percent) exceeded the statewide average for Follow-Up Within 7 Days of an Emergency Department (ED) Visit for SUD.

While there are no recommendations for improvement related to the RAEs' information systems (IS) standards review, there are opportunities for improvement in performance. Due to the statewide averages for the RAEs falling below the performance targets in all performance measures, the Department will further collaborate with the RAEs to identify interdependencies across the measures (e.g., access to timely outpatient services, etc.), in order to target a specific intervention for the next year that could positively impact rates for multiple measures. Furthermore, the Department is considering convening a forum in which the higher performing RAEs could share best practices while all RAEs collaborate on program wide solutions to common barriers. The Department supports these efforts by monitoring the RAEs' progress through routine meetings and informal written updates as the Department determines to be most effective and appropriate

HEDIS measure Rates and Validation – MCO Capitation Initiative
Information Systems Standards Review

The Department reviewed the HEDIS Final Audit Reports produced by each MCO's licensed HEDIS auditor. For the current reporting period, both MCOs were fully compliant with all IS standards relevant to the scope of the performance measure validation performed by the MCOs' licensed HEDIS auditor. During review of the IS standards, the MCOs' HEDIS auditors identified no notable issues with negative impact on HEDIS reporting. Therefore, the Department determined that the data collected and reported for the identified selected measures followed NCAQ HEDIS methodology; and the rates and audit results are valid, reliable, and accurate.

Performance Measure Results

Figure 13 and Figure 14 display the Medicaid statewide weighted averages for HEDIS 2018 through HEDIS 2020, along with the percentile ranking for each HEDIS 2020 rate for the high- and low performing measure rates for the MCO capitation initiative health plans (Denver Health Medical Plan [DHMP] and Rocky Mountain Health Plans Medicaid Prime [RMHP Prime]). Statewide performance measure results for HEDIS 2020 were compared to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2019 when available. Additionally, rates for HEDIS 2020 shaded green with one caret (^) indicate statistically significant improvement in performance from the previous year. Rates for HEDIS 2020 shaded red with two carets (^^) indicate statistically significant decline in performance from the previous year.1-1

Statewide Strengths Related to HEDIS Rates and Validation

Figure 13 MCO Capitation Initiative Statewide Weighted Averages – HEDIS 2020 High Performers

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Childhood Immunization Status				
Combination 6	43.32%	45.20%	47.85%	75th–89th
Combination 8	42.47%	45.14%	47.85%	75th–89th
Combination 9	39.44%	40.76%	42.68%	75th–89th
Combination 10	38.74%	40.70%	42.68%	75th–89th
Immunizations for Adolescents				
Combination 2 (Meningococcal, Tdap, HPV)	47.11%	48.70%	50.04%	≥90th
Preventive Screening				
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.34%	0.23%	0.30%	75th–89th
Mental/Behavioral Health				
Antidepressant Medication Management				
Effective Acute Phase Treatment	53.45%	53.24%	65.91%^	75th–89th
Effective Continuation Phase Treatment	34.05%	33.91%	52.03%^	≥90th
Living With Illness				
Statin Therapy for Patients With Diabetes				
Statin Adherence 80%[1]	58.63%	60.40%	74.16%^	≥90th
Statin Therapy for Patients With Cardiovascular Disease				
Statin Adherence 80%—Total[1]	64.22%	64.89%	77.24%^	≥90th
Medication Management for People With Asthma				
Medication Compliance 50%—Total	57.27%	60.91%	69.66%^	75th–89th
Medication Compliance 75%—Total	31.54%	35.00%	47.47%^	75th–89th
Opioids				
Use of Opioids From Multiple Providers*				
Multiple Pharmacies	—	8.23%	3.73%^	75th–89th

1-1 Performance comparisons are based on the Chi-square test of statistical significance with a p value < 0.05. Therefore, results reporting the percentages of measures that changed significantly from HEDIS 2019 rates may be understated or overstated.

*For this indicator, a lower rate indicates better performance. 1 Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 and prior years be considered
with caution.

— Indicates that NCQA recommended a break in trending for HEDIS 2019; therefore, the HEDIS 2018 rate is not displayed.

The HEDIS 2020 statewide weighted averages for measures within the Pediatric Care and Preventive Screening domains were primarily representative of DHMP's performance, as RMHP Prime's child members include only children with disabilities in six counties in western Colorado. DHMP demonstrated strong performance with immunizations for adolescents, driven by the high inoculation rates of the human papillomavirus (HPV) vaccine series. Additionally, DHMP's rate for the Non-Recommended Cervical Cancer Screening in Adolescent Females measure exceeded the 90th percentile. Conversely, RMHP Prime's rate for the Non-Recommended Cervical Cancer Screening in Adolescent Females measure fell below the 25th percentile.

In the Mental/Behavioral Health domain, the HEDIS 2020 statewide weighted average for the Antidepressant Medication Management measure indicators exceeded the 75th percentile, with RMHP Prime's rates exceeding the 90th percentile for both measure indicators. Conversely, DHMP's rates exceeded the 75th percentile and 50th percentile, respectively, for the Effective Acute Phase Treatment indicator and Effective Continuation Phase Treatment indicator. Although the HEDIS 2020 statewide weighted average for the Medication Management for People with Asthma indicators exceeded the 75th percentile, DHMP's rates did not exceed the 75th percentile while RMHP Prime's rates exceeded the 90th percentile.

The HEDIS 2020 statewide weighted average for measures within the Living with Illness domain demonstrated strong performance, with adherence to statin therapies for patients with diabetes and cardiovascular disease exceeding the 90th percentile. DHMP and RMHP Prime exhibited statistically significant increases in rates for Statin Therapy for Patients with Diabetes—Statin Adherence 80% and RMHP Prime's rate for Statin Therapy for Patients with Cardiovascular Disease—Statin Adherence 80%—Total also was a statistically significant increase.

The HEDIS 2020 statewide weighted average for the measure Use of Opioids from Multiple Providers—Multiple Pharmacies measure in the Opioids domain exceeded the 75th percentile, demonstrating a strength related to members receiving opioids from four or more pharmacies throughout the measurement period.

Figure 14
Statewide HEDIS Results – MCOs- Low Performing Rates

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Pediatric Care				
Well-Child Visits in the First 15 Months of Life				
*Zero Visits**	9.12%	7.08%	4.83%	<10th
Six or More Visits	4.39%	52.28%	55.51%	10th–24th
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.89%	63.57%	64.49%	10th–24th
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	34.29%	39.36%	38.21%	10th–24th
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	16.52%	21.62%	24.76%^	<10th
Counseling for Nutrition—Total	6.14%	7.57%	9.36%	<10th
Counseling for Physical Activity—Total	1.35%	5.81%	7.96%	<10th
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners[1]				
Ages 12 to 24 Months	86.85%	88.52%	89.12%	<10th
Ages 25 Months to 6 Years	72.27%	75.14%	74.56%	<10th
Ages 7 to 11 Years	75.68%	80.16%	80.17%	<10th
Ages 12 to 19 Years	75.68%	80.50%	79.40%	<10th
Adults' Access to Preventive/Ambulatory Health Services				
Total	62.88%	61.75%	63.01%	<10th
Preventive Screening				
Breast Cancer Screening				
Breast Cancer Screening	50.53%	48.53%	47.09%	<10th
Cervical Cancer Screening[1]				
Cervical Cancer Screening	43.12%	42.52%	42.52%	<10th
Adult BMI Assessment				
Adult BMI Assessment	47.08%	52.30%	59.16%^	<10th

***Due to changes in the technical specifications for this measure, NCQA recommends trending between 2020 and prior years be considered with caution. Rates for HEDIS 2020 shaded green with one caret (^) indicated statistically significant improvement in performance form the previous year.**
Statewide HEDIS Results – MCOs- Low Performing Rates (cont.)

Statewide HEDIS Results – MCOs- Low Performing Rates (cont.)

Performance Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	Percentile Ranking
Living With Illness				
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	66.18%	50.98%	70.21%	10th–24th
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	83.03%	83.24%	83.74%	10th–24th
*HbA1c Poor Control (>9.0%)**	56.53%	56.98%	56.95%	10th–24th
HbA1c Control (<8.0%)	35.51%	34.71%	35.37%	10th–24th
Eye Exam (Retinal) Performed	27.40%	47.83%	47.75%	10th–24th
Medical Attention for Nephropathy	82.72%	82.30%	83.50%	<10th
Blood Pressure Control (<140/90 mm Hg)	32.61%	37.14%	38.27%	<10th
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	49.60%	52.77%	53.27%	<10th
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	73.19%	68.18%	66.31%	<10th
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	50.53%	47.02%	50.88%	10th–24th
Bronchodilator	61.10%	67.02%	66.43%	<10th
Asthma Medication Ratio				
Total	59.69%	49.08%	47.31%	<10th
Opioids				
Use of Opioids From Multiple Providers*				
Multiple Prescribers	—	22.10%	39.96%^^	<10th

*For this indicator, a lower rate indicates better performance

- Indicates that NCQA recommended a break in trending for HEDIS 2019; therefore, the HEDIS 2018 rate is not displayed

Rates for HEDIS 2020 Shaded red with tow carets (^^) indicated statistically significant decline in performance from the previous year.

For HEDIS 2020, DHMP and RMHP Prime continued to demonstrate low performance for measures related to comprehensive well-child/well-care visits and ensuring that children and adolescents receive comprehensive visits that follow the American Academy of Pediatrics' (AAP's) Recommendations for Preventive Pediatric Health Care. 1-2

All DHMP's rates within the Access to Care domain were below the 10th percentile. The measures related to preventive screenings for women (Breast Cancer Screening and Cervical Cancer Screening) for DHMP also fell below the 10th percentile. RMHP Prime's rates for measures within the Access to Care domain were below the 50th percentile and were below the 25th percentile for measures related to preventive screenings for women.

Six of 12 (50 percent) measure rates within the Living with Illness domain that were determined to be low performers for HEDIS 2020 were related to the appropriate prescribing of and/or monitoring of members prescribed long-term medications. Further, all measures within this domain fell below the 25th percentile.

The HEDIS 2020 statewide weighted average for the Use of Opioids from Multiple Providers—Multiple Prescribers measure in the Opioids domain fell below the 10th percentile and was a statistically significant decline in performance from the previous year, demonstrating an opportunity related to members receiving opioids from four or more different prescribers throughout the measurement period.

The MCOs' HEDIS compliance Final Audit Reports indicated that both MCOs followed NCQA methodology, and that the rates submitted were valid, reliable, and accurate. Therefore, HSAG identified no opportunities for improvement or recommendations related to the IS standards review.

Based on performance measure results, HSAG recommends that the Department and the MCOs conduct a root cause analysis of the barriers to achieving improved performance in measures in the Pediatric Care and Access to Care domains. For example, are the low measure rates related to barriers to accessing care, the need for community outreach and education, provider billing issues, or administrative data source challenges? Once the causes are identified, the MCOs and the Department should consider identifying an intervention with the ability to reach and impact the highest number of members (i.e., high impact area), then work with providers and members, as applicable to the intervention, to improve member access, which will subsequently increase performance in these measure rates.

Related to substantially low performance in the Living with Illness domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to perform root cause analysis to determine the reason these measures continue to have low rates (e.g., is there a focus or a dedicated intervention approach to identifying and resolving potential barriers to filling prescriptions, or the need for community outreach and education on side effects or alternatives to certain medication therapies) and implement strategies that focus on improving the care for members related to these measures.

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1-2 American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Sept 14, 2020.

Related to low statewide scores in the Breast Cancer Screening and Cervical Cancer Screening measures, HSAG continues to recommend that the MCOs consider implementing or improving efforts to expand access to these screenings. This may include the MCOs following up with providers when members are overdue for a screening or working with providers to send reminders to members about scheduling an appointment. Best practices include sending reminders in the mail, calling members to schedule screenings, offering flexible or extended office hours, or offering mobile mammogram screenings.1-3

Related to low statewide scores in the Opioids domain, HSAG recommends that both DHMP and RMHP Prime work with the Department to identify and monitor prescribing practices for opioids to treat chronic pain. Guidelines for prescribing opioids for chronic pain include improving communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improving the safety and effectiveness of pain treatment, and reducing the risks associated with long-term opioid therapy.1-4

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1-3 The Community Guide. Cancer Screening: Evidenced-Based Interventions for Your Community. Available at: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-CancerScreening.pdf. Accessed on: Sept 14, 2020.
1-4 Guideline for Prescribing Opioids for Chronic Pain. Available at: https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf. Accessed on: Sept 14, 2020.

Medical Loss Ratios

The Department evaluates Medical Loss Ratio's (MLR) for its managed care entities Rocky Mountain Health Plan (RMHP) and Denver Health Medical Center based on the percent of premium used to pay for medical claims and activities that improve the quality of care; a basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to Health First Colorado Medicaid members. Annual measurement periods align with the state fiscal year, beginning on July 1 and ending on June 30 of the subsequent calendar year. Target goals in relation to performance are reflected in Figure 15.

Figure 15

RMHP

Measure	2017-18 Goal	2017-18 Performance	2018-19 Goal	2018-19 Performance	2019-20 Goal	2019-20 Performance
Diabetes Poor Control <9%	29.23%	27.92%	23.50%	20.01%	19.5%	20.03%
SUD ER Rate	N/A	N/A	17.50%	19.06%	17.5%	16.66%
Depression Screening & Follow-up	55.63%	64.94%	64.00%	66.35%	70.0%	67.27%
Patient Activation	30.00%	43.90%	41.00%	43.20%	45%	49.66%

DHMC

Measure	2017-18 Goal	2017-18 Performance	2018-19 Goal	2018-19 Performance	2019-20 Goal	2019-20 Performance
Diabetes Screening	N/A	N/A	83.14%	82.06%	N/A	N/A
Childhood Immunization	N/A	N/A	57.29%	56.61%	57.75%	57.63%
Well Child Check (3-6)	N/A	N/A	62.81%	63.59%	N/A	N/A
Depression Screening & Follow-up	N/A	N/A	50.00%	40.00%	N/A	N/A
Timeliness of Prenatal Care	N/A	N/A	64.93%	71.90%	73.81%	84.53%

The Department continues to work with RMHP and DHMC in implementing a rapid-cycle improvement plan for driving systematic and continuous improvement for Diabetes Poor Control <9%, Depression Screening & Follow-up, and Patient Activation, and Childhood Immunization in order to achieve the defined performance goals.

Encounter Data Validation

The RAE 411 overread evaluated each RAE's compliance with the Department's BH encounter data submission standards, as well as the consistency and accuracy with which each RAE uses Medical Record Reviews to validate its BH Encounter data. The Department's over-read evaluated whether the RAEs' internal validation results were consistent with Colorado's USCS manuals specific to the study period. The Department entered all overread results into a standardized data collection tool that aligned with the Department's Annual RAE BH Encounter Data Quality Review Guidelines. The Department tabulated the over-read results by service category to determine the percentage of overread cases and encounter data elements for which the Department agreed with the RAEs' Encounter Data Validation (EDV) responses.

Statewide BH RAE 411 Overread Results

BH Service Category	Number of Cases with *Validation Elements* Agreement	Percent of Cases with *Validation Elements* Agreement*	Number of Data Elements in Agreement	Percent of Data Elements in Agreement**
Prevention/Early Intervention Services	64	91.4%	733	95.2%
Club House or Drop-In Center Services	63	90.0%	729	94.7%
Residential Services	65	92.9%	757	98.3%
Total	**192**	**91.4%**	**2,219**	**96.1%**

** HSAG overread 10 cases from each RAE for each BH service category (i.e. a denominator of 70 cases per service category)*

*** HSAG overread 11 individual data elements for each case, resulting in 110 data elements per RAE and a denominator of 770 data elements per service category.*

MCO 412 Self-Reported EDV Results

The MCO 412 audit overread evaluated each MCO's compliance with the Department's encounter data submission standards, as well as the consistency and accuracy with which each MCO uses MRR to validate its encounter data. The Department's overread evaluated whether the MCOs' internal validation results were accurate based on the review of the encounter data and corresponding medical record documentation. The Department entered all overread results into a standardized data collection tool that aligned with the Department's Annual MCO Encounter Data Quality Review Guidelines. The Department tabulated the overread results by service category to determine the percentage of overread cases and encounter data elements for which HSAG agreed with the MCOs' EDV responses.

Data Element	Inpatient Encounters	Outpatient Encounters	Professional Encounters	FQHC Encounters	Aggregate Results
Date of Service	89.3%	80.1%	83.0%	86.9%	84.8%
Through Date	89.8%	NA	NA	NA	89.8%
Primary Diagnosis Code	85.0%	70.4%	68.3%	76.2%	75.0%
Primary Surgical Procedure Code	87.7%	NA	NA	NA	87.7%
Discharge Status	90.3%	NA	NA	NA	90.3%
Procedure Code	NA	61.9%	70.9%	68.9%	67.3%
Procedure Code Modifier	NA	74.3%	79.6%	83.4%	79.3%
Units	NA	64.5%	82.5%	84.4%	77.3%

Each service category has a modified denominator based on the MCO's 412 Service Coding Accuracy Report Summary.

MCO 412 Over-Read Results

Service Category	Case-Level Accuracy—Total Number of Cases Overread*	Case-Level Accuracy—Percent of Cases With Complete Agreement	Element-Level Accuracy—Total Number of Elements Overread	Element-Level Accuracy—Percent of Elements With Complete Agreement
Inpatient	42	100.0%	252	100.0%
Outpatient	38	84.2%	190	93.7%
Professional	40	97.5%	200	97.5%
FQHC	40	85.0%	200	96.0%
Total	**160**	**91.9%**	**842**	**97.0%**

HSAG sampled 20 cases per MCO from each service category (i.e. 40 cases total per service category), and the MCO's EDV determined that two over-read cases originally sampled as Outpatient services had medical record documentation to support Inpatient services: these cases were validated by the MCO and overread by HSAG as Inpatient cases.

EPSDT Participation Report (form CMS-416)

The EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental and specialty services. The Form CMS-416 is used by CMS to collect basic information from the Department on the States Medicaid and CHIP programs to assess the effectiveness of EPSDT. Annually the Department must provide CMS with information related to 1) Number of children provided child health screening service, 2) Number of children participating in Services, 3 Number of children referred for corrective treatment, 4) number of

children receiving dental services, and 5) Lead Testing Form 416 provides CMS our Department Results in attaining goals set. The Departments EPSDT Participation Report may be found at:

https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt

- Note: The Annual CMS 416 Report is due to CMS April 1st of each year at which point the Department will provide an evaluation and effectiveness review for EPSDT.

Validation of Performance Improvement Projects

Due to the COVID-19 pandemic, the Department decided to close out the PIPs at the end of FY 2019–2020, prior to the completion of Module 4 and Module 5. The RAEs were instructed to submit a PIP close-out report and will initiate a new round of PIPs in FY 2020–2021. The health plans achieved all validation criteria for Module 3 of the PIPs; therefore, there were no identified opportunities for improvement, based on the FY 2019–2020 PIP validation findings. Although the PIPs were closed out early, due to the COVID-19 pandemic, the RAEs will have lessons learned from working on Colorado's first round of rapid-cycle PIPs. Health Plans have begun new Performance Improvement Projects for FY 20-21 based on Screening for Depression and Follow-up after a Positive Depression Screen. Performance Improvement Project measurement for the new PIP topic will be monitored and reported upon completion of the 18-month Rapid Improvement Cycle.

Figure 16 displays the results of the FY 2019–2020 PIP validations and summarizes how far through the five modules of the rapid-cycle PIP process each RAE progressed.

Figure 16 Statewide PIP Results

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 1—Rocky Mountain Health Plans				
	ACC	*Improving Well-Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members Ages 15–18*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Increase the Number of Depression Screenings Completed for Regional Accountable Entity (RAE) Members Ages 11 and Older*	*Completed Module 3 and Initiated Module 4*	NA*
	MCO	*Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*	*Completed Module 3 and Initiated Module 4*	NA*
Region 2—Northeast Health Partners				
	ACC	*Increasing Well Checks for Adult Members 21–64 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 3—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*

Validation of PIPs Summary of Scores – RAE ACC, BH, and MCO PIPS (cont.)

RAE	PIP Type	PIP Topic	Module Status	Validation Status
Region 4—Health Colorado, Inc.				
	ACC	*Increasing Well Checks for Adult Members 21–64 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Increasing Mental Healthcare Services After a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 5—Colorado Access				
	ACC	*Well-Child Visits for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Referral From Primary Care to Behavioral Health Following a Positive Depression Screening for Members 10–14 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	MCO	*Improving Adolescent Well-Care Access for Denver Health Medicaid Choice Members 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
Region 6—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*
Region 7—Colorado Community Health Alliance				
	ACC	*Well-Care Visits for Children Ages 15–18 Years of Age*	*Completed Module 3 and Initiated Module 4*	NA*
	BH	*Supporting Members' Engagement in Mental Health Services Following a Positive Depression Screening*	*Completed Module 3 and Initiated Module 4*	NA*

**NA—No PIPs progressed to being evaluated on outcomes or receiving a final validation status during the FY 2019–2020 validation cycle.*

Annual Quality Improvement Plans

The Department's Quality Strategy is designed for overseeing, creating and administering activities related to the Department's quality initiatives associated with improved health outcomes for our Health First Colorado Medicaid members, contract deliverables, and better healthcare delivery. As part of this strategy the Department works in collaboration with our EQRO and our RAE's in detailing the progress and effectiveness of each component of their Quality Improvement Plans. Each RAE develops a plan to provide a formal ongoing process by which the Department and the RAEs' utilize objective measures to monitor and evaluate the quality of services provided. Evaluation is often an annual evaluation of the prior year's quality improvement activities which includes recommendations for the following year. RAE Quality plans with defined priorities are located at: https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-deliverables

Validation of Network Adequacy

Access Standards
§438.206(c)(1)

Under the contract for EQRO, the Department requested HSAG to conduct baseline network adequacy validation (NAV) analyses of the Medicaid and CHP+ provider networks for 16 managed care entities (MCEs) during fiscal year (FY) 2019–2020. In preparation for FY 2020–2021, the Department also requested HSAG develop quarterly network adequacy reporting templates for each MCE type and collaborate with the Department to implement the templates during early 2020.

The FY 2019–2020 geospatial analyses include all ordering, referring, and servicing practitioners; practice sites; and entities (e.g., healthcare facilities) contracted to provide care as of October 1, 2019, through one of the following Health First Colorado1-1 or CHP+ MCEs:

- Six CHP+ Plans1-2
  - Colorado Access CHP+ Managed Care Organization (COA CHP+ MCO)
  - Colorado Access CHP+ State Managed Care Network (COA SMCN)
  - Denver Health Medical Plan CHP+ (DHMP CHP+)
  - Friday Health Plans (FHP)
  - Kaiser Permanente (Kaiser)
  - Rocky Mountain Health Plans CHP+ (RMHP CHP+)
- Two Limited Managed Care Capitated Initiative Plans (Medicaid MCOs)
  - Denver Health Medical Plan MCO (DHMP)
  - Rocky Mountain Health Plans—Prime (RMHP Prime)
- One CHP+ Prepaid Ambulatory Health Plan (PAHP)
  - DentaQuest
- Seven Regional Accountable Entities (RAEs), including each RAE's physical health and behavioral health networks
  - RAE 1: Rocky Mountain Health Plans (RMHP)
  - RAE 2: Northeast Health Partners, LLC (NHP)1-3
  - RAE 4: Health Colorado, Inc. (HCI)1-4
  - RAEs 3 and 5: Colorado Access (RAE 3: COA, RAE 5: COA)
  - RAEs 6 and 7: Colorado Community Health Alliance (RAE 6: CCHA, RAE 7: CCHA)

The FY 2019–2020 network adequacy study included data collection, synthesis and analysis, and reporting phases. During the data collection task, HSAG requested member data and copies of the MCEs' quarterly network adequacy reports from the Department, and the network data from the MCEs.

HSAG reviewed the member and network data, including follow-up with the Department and the MCEs prior to cleaning the data for analyses. During the synthesis and analysis phase, HSAG conducted geo access analyses to assess the MCEs' compliance with network contractually required provider-to member ratio standards or time and distance standards (contract standards), as well as collaborating

with the Department to develop quarterly network adequacy reporting templates that were standardized across the MCE types. The final study phase included implementation of the quarterly network adequacy reporting templates and describing the geo access analysis results in this report

NAV Results

CHP + Health Plans

This section summarizes the NAV findings specific to the following six CHP+ plans

- COA CHP+ MCO
- COA SMCN
- DHMP CHP+
- FHP
- Kaiser
- RMHP CHP+

Network Capacity

The below table summarizes the count of provider ratio standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met for each of the CHP+ plans by county classification. For example, if the CHP+ plan had assigned members in five urban counties, with seven standards assessed for each county, the "Count of Standards" column would indicate that 35 standards were considered for the provider ratio calculations. HSAG's network counts for ratio calculations are limited to the unique practitioner, practice site, or entity within the network category, not the number of practice locations attributable to each individual practitioner.

Provider Ratios by CHP+ Plan and Count Classification

CHP+ Plan	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
COA CHP+ MCO	33	23	69.7%	19	18	94.7%	19	19	100%
COA SMCN	33	32	97.0%	33	33	100%	33	33	100%
DHMP CHP+	19	18	94.7%	18	17	94.4%	NA	NA	NA
FHP	18	18	100%	19	19	100%	19	19	100%
Kaiser	33	32	97.0%	18	18	100%	18	18	100%
RMHP CHP+	19	18	94.7%	19	17	89.5%	19	18	94.7%

NA indicates that no standards are applicable to county and network category for the MCE; therefore, the percentage of standards met was not calculated.

Medicaid MCOs

This section summarizes the NAV findings specific to the following Medicaid MCOs:

- DHMP
- RMHP

Network Capacity

The below table summarizes the count of provider ratio standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met for each of the Medicaid MCOs by county classification. For example, if the Medicaid MCO had assigned members in five urban counties, with seven standards assessed for each county, the "Count of Standards" column would indicate that 35 standards were considered for the provider ratio calculations. HSAG's network counts for ratio calculations are limited to the unique practitioner, practice site, or entity within the network category, not the number of practice locations attributable to each individual practitioner.

Provider Ratio Results by Medicaid MCO and County Classification

Medicaid MCO	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
DHMP	28	21	75.0%	28	28	100%	28	28	100%
RMHP Prime	28	26	92.9%	28	26	92.9%	28	26	92.9%

Dental Prepaid Ambulatory Health Plan (PAHP)

This section presents findings for the CHP+ PAHP, DentaQuest, which is contracted with the Department to serve all Colorado counties.

Since the PAHP is only responsible for dental services with time/distance network standards, analytic results for DentaQuest are limited to evaluation of time/distance calculations for the Dental Services network domain and corresponding network categories. Provider ratio contract standards are not applicable for the PAHP; therefore, no results are displayed in this report. The Department's member data included individuals assigned to DentaQuest and 100 percent (n=73,166) of DentaQuest's assigned members had a residential address in a contracted county. County-specific time/distance compliance results are shown below for all counties in which DentaQuest had assigned members.

The below table summarizes the time/distance compliance results for DentaQuest by network category and county classification.

Time/Distance Results for DentaQuest by Network Category and County Classification

Network Category	Urban		Rural		Frontier	
	Count of Counties	% of Standards Met	Count of Counties	% of Standards Met	Count of Counties	% of Standards Met
Dental Hygienists	14	42.9%	27	55.6%	23	39.1%
General Dentists	14	71.4%	27	96.3%	23	91.3%
Pediatric Dentists	14	57.1%	27	44.4%	23	8.7%
Endodontists	14	14.3%	27	3.7%	23	4.3%
Oral Surgeons	14	50.0%	27	11.1%	23	8.7%
Orthodontists	14	42.9%	27	11.1%	23	8.7%
Periodontists	14	14.3%	27	0.0%	23	0.0%
Prosthodontists	14	0.0%	27	11.1%	23	8.7%

While DentaQuest failed to meet all network access standards in all counties, the percent of standards met among the network categories ranged from 0 percent to 71.4 percent in urban counties, 0 percent to 96.3 percent in rural counties, and 0 percent to 91.3 percent in frontier counties.

Regional Accountable Entities (RAEs)

This section summarizes the NAV findings specific to the following RAEs:

- RAE 1: RMHP
- RAE 2 NHP
- RAE 4 HCI
- RAEs 3 and 5: COA Region 3 and COA Region 5
- RAEs 6 and 7: CCHA Region 6 and CCHA Region 7

Network Capacity

The below summarizes the count of provider ratio standards (i.e., the overall number of network standards applicable across the counties), the count of standards met, and the percentage of standards met for each of the RAEs by county classification. For example, if the RAE had assigned members in five rural counties, with five standards assessed for each county, the “Count of Standards” column would indicate that 25 standards were considered for the provider ratio calculations. HSAG’s network counts for ratio calculations are limited to the unique practitioner, practice site, or entity within the network category, not the number of practice locations attributable to each individual practitioner.

Provider Ratio Results by RAE and County Classification

RAE	Urban			Rural			Frontier		
	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met	Count of Standards	Count of Standards Met	% of Standards Met
RAE 1: RMHP	14	13	92.9%	14	10	71.4%	14	13	92.9%
RAE 2: NHP	14	8	57.1%	14	12	85.7%	14	12	85.7%
RAE 3: COA	14	10	71.4%	14	12	85.7%	14	12	85.7%
RAE 4: HCI	14	11	78.6%	14	11	78.6%	14	12	85.7%
RAE 5: COA	14	10	71.4%	14	12	85.7%	14	12	85.7%
RAE 6: CCHA	14	10	71.4%	14	13	92.9%	14	13	92.9%
RAE 7: CCHA	14	10	71.4%	14	12	85.7%	14	12	85.7%

Full reporting of the Access Standards is located at:
https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-deliverables

The Department has made significant progress during FY 2019-2020 in developing and implementing quarterly network adequacy reporting materials that are standardized within and across MCE types. Under the NAV the Department has taken a critical look at provider data availability, made progress in receiving routine provider files with standard category mapping from MCEs, and validating the MCEs' quarterly time distance reporting results. The Department will continue to refine and automate the quarterly network adequacy reporting to reduce duplication of reporting and oversight efforts for the Department and MCEs and to facilitate routine NAV by an external entity. In addition, the Department will consider conducting an independent network directory review to verify that the MCEs' publicly available network data accurately represent the network data supplied to the members and used for geo access analyses. The Department will continue to assess the number, distribution and availability of the MCEs' network locations and look at a variety of other access related topics (e.g. which providers offer telemedicine). The Department will continue to review member satisfaction survey results and grievance and appeals data to identify which results and complaints are related to members' access to care. Survey results and grievance and appeals data is utilized to evaluate the degree to which members are satisfied with the care they have received and the extent to which unsatisfactory care may be related to an MCE's lack of compliance with network standards.

§438.207(b)(2) Contractors are required to provide a Network Adequacy Report Annually which details each health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians with unreasonable delay. Network Adequacy Reports are located at: https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative-deliverables. In addition, the Department continues to expand provider networks throughout the state to ensure all Health First Colorado Members have access to care.

Other Quality Improvement Initiatives:

Hospital Quality Improvement Program (HQIP)

Program of All-Inclusive Care for the Elderly (PACE)

The Department continues to review each PACE organization's compliance with the requirements of 42 CFR Part 460, including the organization's capacity to provides comprehensive medical and social services to elderly individuals who enroll in the PACE program. While services are furnished across all settings, a primary PACE program objective is to enable participants to live in the community rather than a skilled nursing facility. As part of the review process the Department implemented two (2) uniform surveys to identify areas of opportunity to improve the delivery of services, participant care and overall member satisfaction and experience. For fiscal year 2019-2020, the top three (3) satisfaction concerns identified are:

1. Communication
2. Care Coordination (including lack of follow-up on test results)
3. Specialist (not seen as soon as needed)

The Department Continues to work with PACE organizations to further drive improvement in initiating various performance improvement projects. For FY 20-21, PIPS have been placed on hold due to the unprecedented COVID-19 pandemic. The Department anticipates reengaging these PIP's once the pandemic is over.

Conclusion

Improving the experience of patient care, improving population health, and reducing per capita costs of health care are all key priorities of the Department. To assist the Department in driving performance improvement all contracted health plans are provided with their individuals scores; an assessment of their strengths and weaknesses; and recommendations or required corrective actions for improving quality, timelines, and access to care and services. Health plans are required to take steps that will improve their performance. In addition, the Department continues to identify and incorporate principles of quality improvement initiatives to further achieve an enhanced level of performance which is reliable and cost-effective while providing sustainable processes for achieving identified goals of improving care delivery and enhancing member outcomes.